Bundle Public Trust Board Meeting - Velindre University NHS Trust 27 January 2022

1.0.0 10:00 - STANDARD BUSINESS

1.1.0 APOLOGIES

Led by Prof Donna Mead OBE, Chair

1.2.0 IN ATTENDANCE

Led by Prof Donna Mead OBE, Chair

1.3.0 DECLARATIONS OF INTEREST

Led by Prof Donna Mead OBE, Chair

2.0.0 CONSENT ITEMS

2.1.0 FOR APPROVAL

Led by Prof Donna Mead OBE, Chair

2.1.1 Minutes from the Public Trust Board meeting held on 25 November 2021

Led by Prof Donna Mead OBE, Chair

2.1.1 DRAFT MINUTES _Public_Trust_Board_Meeting_25_November_2021 v3 -LF.docx

2.1.2 Chair's Urgent Actions Report

Led by Prof Donna Mead OBE, Chair

2.1.2 Chairs Urgent Action Report_January 2022.docx

2.1.3 Commitment of Expenditure Exceeding Chief Executive's Limit

Led by Matthew Bunce, Executive Director of Finance

Trust Board January 2022_Commitment of Expenditure Cover Paper.docx

Appendix 1 - Professional Services Appointment_.docx

Appendix 2 - Welsh Government Emergency Lighting_ (003) (003).docx

Appendix 3 - Commitment of Expenditure Over Chief Exec Limit - Varian Parts Order - Endorsed.docx

Appendix 4 - Commitment of Expenditure Over Chief Exec Limit_MLC Refurbishment.docx

2.1.4 Revisions to Velindre University NHS Trust Model Standing Orders Schedule 3

Led by Lauren Fear, Director of Corporate Governance and Chief of Staff

2.1.4 Amendment to Standing Orders Cover Paper_January 2022.docx

2.1.4 a1 SDC TOR - without track changes.docx

2.1.4 b2 AC TOR - without track changes.docx

2.1.4 c1 CFC TOR - without track changes.docx

2.1.4 d1 QSP TOR - without track changes.docx

2.2.0 FOR NOTING

Led by Prof Donna Mead OBE, Chair

2.2.1 Remuneration Committee Highlight Report

Led by Prof Donna Mead OBE, Chair

2.2.1 Rem Comm Highlight Report - 13.12.2021.docx

2.2.2 Local Partnership Forum Highlight Report

Led by Sarah Morley, Executive Director of Organisational Development & Workforce

2.2.2 LPF Highlight Report - Board Jan 2022.docx

2.2.3 Transforming Cancer Services Programme Scrutiny Sub-Committee Highlight Report

Led by Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee

2.2.3a PUBLIC TCS Programme Scrutiny Committee Highlight Report 25th October 2021 - QSP.docx

2.2.3b PUBLIC TCS Programme Scrutiny Committee Highlight Report 22nd November 2021 - QSP.docx

2.2.4 Transforming Cancer Services Communication & Engagement Update

Led by Lauren Fear, Director of Corporate Governance and Chief of Staff

2.2.4 Communications Engagement Jan 2022-Trust Board.docx

2.2.5 Audit Committee Highlight Report

Led by Martin Veale, Independent Member and Chair of the Audit Committee

2.2.5 Audit Committee Highlight Report 24 01 2022 Final Version.docx

2.2.5a Audit Committee Annual Report Jan - Dec 2021 final.docx

2.2.6 Strategic Development Committee Highlight Report

Led by Stephen Harries, Independent Member and Chair of the Strategic Development Committee

2.2.6 Public - Strategic Development Committee Highlight Report 09.12.2021 DRAFT-LF.docx

2.2.7 Brachytherapy Update

Led by Cath O'Brien, Chief Operating Officer

2.2.8 Brachytherapy TRUST BOARD January 22 FINAL 21.1.21.docx

2.2.8 WHSSC Joint Committee Briefing

Led by Lauren Fear, Director of Corporate Governance and Chief of Staff
The Welsh Health Specialised Services Committee held its latest public meeting on 11th January 2022. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

2.2.9 2022-01-11 JC (Public) Briefing.pdf

3.0.0 10:05 - MATTERS ARISING

Led by Prof Donna Mead OBE, Chair

3.1.0 Action Log

Led by Prof Donna Mead OBE, Chair

PUBLIC TRUST BOARD ACTION LOG_27.01.22 v1.docx

4.0.0 10:20 - INTEGRATED GOVERNANCE

4.1.0 10:20 - Audit Wales Annual Report

Led by Clare James and Katrina Febry, Audit Wales

4.1.0 2742A2021-22_Velindre_AAR_2021_Eng.pdf

5.0.0 10:40 - KEY REPORTS

5.1.0 10:50 - Chairs Update

Led by Prof Donna Mead OBE, Chair

5.1.0 Chair Update Report Jan 27.01-DM.docx

5.2.0 11:00 - CEO Update

Led by Steve Ham, Chief Executive

5.2 CEO Update Report January 2022 - Final draft LF.docx

6.0.0 QUALITY, SAFETY & PERFORMANCE

6.1.0 11:10 - Quality, Safety & Performance Committee Highlight Report

6.1.0 Public Quality Safety Performance Committee Highlight Report 20.1.22(v4approved).docx

6.2.0 11:20 - Covid- 19 Update Report

Led by Cath O'Brien, Chief Operating Officer. Nicola Williams, Executive Director of Nursing, Allied Health Professions and Health Scientists, Sarah Morley, Executive Director of Organisational Development & Workforce and Lauren Fear, Director of Corporate Governance & Chief of Staff

6.2.0 COVID UPDATE Board Meeting - Trust final 19.1.22.pptx

6.3.0 11:30 - BREAK 11:30 -11:40

6.4.0 11:40 - Delivering Excellence Performance Report Period November 2021

Led by Cath O'Brien, Chief Operating Officer

6.4.0 TRUST BOARD NOVEMBER PMF Cover Paper 11.01.2022 FINAL.docx

6.4.0 TRUST BOARD VCC Performance Report (Nov 2021).docx

6.4.0 WBS November. 2021 PMF Report.pdf

6.4.0 Trust-wide WOD Performance Report - November 2021.pdf

6.5.0 12:10 - Financial Report Period November/December 2021

Led by Matthew Bunce, Executive Director of Finance

6.5.0 Month 8 Finance Report Cover Paper - Trust Board Final.docx

6.5.0 M8 VELINDRE NHS TRUST FINANCIAL POSITION TO NOVEMBER 2021 FINAL.docx

6.6.0 12:20 - VUNHST Risk Register

Led by Lauren Fear, Director of Corporate Governance and Chief of Staff

6.6.0 Trust Board Risk Paper 27.01.2022.docx

6.6.0 Copy of Trust Risk Register VS 12 Public.xlsx

6.6.0 Trust Risk Register Vs 14 Public.xlsx

6.6.0 Risk appendix for Trust Board.docx

6.7.0 12:30 - Trust Assurance Framework

Led by Lauren Fear, Director of Corporate Governance and Chief of Staff

6.7.0 Trust Assurance Framework _ Jan 2022 Trust Board Cover Report.docx

6.7.0 Appendix 1_TAF DASHBOARD.pdf

7.0.0 STRATEGIC DEVELOPMENT

7.1.0 12:40 - Trust Strategy

Led by Carl James, Director of Strategic Transformation, Planning & Digital

7.1.0 TB Paper Trust strategy 2022 2032 jan 27 2022 cj.docx

7.1.0 V2 VELINDRE UNIVERSITY NHS TRUST strategy 2025 DRAFT 31 20 JAN 2022 CJ.pdf

7.2.0 13:10 - Cardiff Cancer Research Hub, Proposal for a Tripartite partnership between Cardiff and Vale UHB, Cardiff University and Velindre University NHS Trust

Led by Dr Mererid Evans, Libby Batt and Phil Hodson, Assistant Director of Planning and Performance

7.2.0 Trust Board - 27th January 2022 - Velindre@UHW - R and D Hub.docx

7.2.0 Annex 1 - Joint Proposal_Cardiff Cancer Centre Final draft v8.pdf

7.2.0 Annex 2 - joint RD proposal.pptx

9.0.0 13:25 - ANY OTHER BUSINESS

Prior Approval by the Chair Required

10.0.0 CLOSE

The Board is asked to adopt the following resolution:
That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

11.0.0 13:30 - DATE AND TIME OF THE NEXT MEETING

Thursday, 31 March 2021 at 10:00

MINUTES PUBLIC TRUST BOARD MEETING – PART A

VELINDRE UNIVERSITY NHS TRUST HQ/LIVE STREAMED
25 NOVEMBER 2021 @ 10:00

PRESENT	
Professor Donna Mead OBE	Chair (Chair)
Stephen Harries	Interim Vice Chair
Martin Veale	Independent Member
Hilary Jones	Independent Member
Gareth Jones	Independent Member
Vicky Morris	Independent Member
Professor Andrew Westwell	Independent Member
Steve Ham	Chief Executive
Nicola Williams	Executive Director of Nursing, AHPs & Health Scientists
Matthew Bunce	Executive Director of Finance
Dr Jacinta Abraham	Executive Medical Director
Sarah Morley	Executive Director of Organisational Development & Workforce
ATTENDEES:	
Lauren Fear	Director of Corporate Governance and Chief of Staff
Cath O'Brien MBE	Chief Operating Officer
Emma Stephens	Head of Corporate Governance
Kay Barrow	Corporate Governance Manager, Secretariat

1.0.0	STANDARD BUSINESS	ACTION LEAD
1.1.0	**Welcome and Introductions** Prof Donna Mead welcomed everyone to the meeting and, in particular, Margaret Foster, Chair of the NHS Wales Shared Services Committee. Prof Donna Mead explained that she had asked Margaret to attend the Trust Board meeting so that the Trust Board could formally mark her retirement at the end of November 2021. Prof Donna Mead reflected that both she and Margaret had commenced their careers in the same year, and that their paths had crossed in various roles over the years. Margaret's career had been an illustrious one, in which she had held a number of key appointments, latterly in NHS Wales and, at present, also holding the position of Commissioner in the Isle of Anglesey County Council appointed by the Minister for Local Government. Prof Donna Mead, on behalf of the Trust Board, thanked Margaret for her support, hard work and leadership in NHS Wales Shared Services Partnership, much of which had been behind the scenes. The Trust	

	Board wished Margaret all the very best in her retirement and that it would also be marked by a special delivery to her home during the day. Margaret Forster thanked the Trust Board for inviting her to attend the Trust Board and for the warm wishes that had been extended to her in her retirement. She commented that she had enjoyed the roles held, and, in particular, as Chair of the NHS Wales Shared Services Partnership and the relationships made with the Trust as a hosted organisation. Margaret Foster left the meeting.	
1.2.0	**Apologies** Apologies were received from Carl James, Director of Strategic Transformation, Planning & Digital.	
1.3.0	**In Attendance** Prof Donna Mead welcomed Vicky Morris to her first Trust Board meeting since her Welsh Government appointment as the Trust's new Independent Member for Quality & Safety. Prof Donna Mead also welcomed the regular attendees of the Trust's Public Trust Board meeting, as follows: • Stephen Allen, Chief Officer, Cardiff Community Health Council • David Cogan, Patient Liaison Representative • Katrina Febry, Audit Lead Performance, Audit Wales (Observer) • Internal Audit colleagues (Observers) In addition, a warm welcome was extended to the following Trust Board meeting attendees: • Phil Hodson, Deputy Director of Planning & Performance who was attending for Carl James • Stephen Harrhy, Board Director/Chief Ambulance Service Commissioner for Agenda Item 2.1. • Dr Chris Turner, Interim Chair, National Collaborative Commissioning Unit for Agenda Item 2.1. • Richard Baxter, Taskforce Project Manager for Agenda Item 2.1.	
1.4.0	**Declarations of Interest** There were no Declarations of Interest.	
2.0.0	**PRESENTATIONS AND GUEST ATTENDEES**	
2.1.0	**Emergency Ambulance Services Committee (EASC) Update** Prof Donna Mead welcomed Stephen Harrhy, Dr Chris Turner and Richard Baxter to the meeting.	

	Dr Chris Turner provided an overview of where the Emergency Ambulance Services Committee (EASC) was placed within the NHS Wales structure explaining the function of the Joint Committee. The Board were advised that EASC predominantly operated on behalf of Health Boards by commissioning services related to emergency ambulance services (EMS), non-emergency patient transport services (NEPTS) and emergency medical retrieval and transfer service (EMRTS Cymru) and worked closely with the Welsh Ambulance Service NHS Trust (WAST). It was highlighted that the Trust had an interest in these services but more so with NEPTS and EMRTS than EMS. Dr Chris Turner provided an overview of the Minister's Priorities for EASC and the requirement to work collaboratively with partners to commission the right services. Stephen Harrhy provided an overview of the Minister's expectations for EASC to undertake an appropriate transformation of its services. A summary of the focused work being taken forward to realise the necessary improvements in ambulance delivery included: • Ensuring a citizen centred approach; • Better understanding and improved productivity; • Understanding the workforce recruitment pipeline; • Understanding the pressures on the workforce and wellbeing; • Better use of digital technology; • Measurement for improvement. A summary of the commissioning intentions for the three commissioned services was provided, in terms of the key priorities and outcomes together with the breakdown of the funding allocation to commission ambulance services A breakdown of the NEPTS Activity was provided which demonstrated that the Trust was mirroring the all Wales position. It was highlighted that the number of aborted patient journeys for the Trust had increased during 2021 compared to 2020, although there was an opportunity for both parties to address this. Aborted patient journeys are defined as journeys that are cancelled on the day or after 12pm on the day before travel. In terms of patient inbound journeys from 2020 to 2021, there was an increase in the use of the volunteer car Service, with a corresponding reduction in ambulance and taxi usage. This demonstrated the requirements for a more tailored service for the Trust based on its patients. Patient outbound journeys for 2021 compared to 2020, showed a significant change in the use of a higher percentage of taxis. However, there was a need to review this to ensure the best value for money with the contract and the balance in terms of the volunteer car service and taxi usage.	

	The response time for an EMS patient inbound journey averaged circa 2 hours with an excellent handover with no delays. The average EMS patient outbound journey was just under 2 hours with a handover of just under 30 minutes. It was highlighted that this was a useful tracking measure ensuring the patient was at the centre of the service provision. It was noted that there was variation depending on which hospital was involved and this data could be provided to assist with areas for opportunity and/or improvement. An overview of the WAST future ambition, as part of the overall EASC transformation trajectory, was provided. Although, there was a need to be mindful and ensure collaborative working to ensure there were no unintended consequences in the service redesign. Steve Ham and Andrew Westwell joined the meeting. The Trust Board welcomed the presentation, which had been a useful overview of the activity against the contract. It highlighted the need to work collaboratively in seeking opportunities to tailor the service provision to best fit with the needs of the patients. Cath O'Brien was keen to build on the relationship with EASC and, in particular, its involvement with the Velindre Futures service transformation work and new ways of working. Stephen Harrhy advised that there was a need to be kept informed of changes so that EASC could adapt the commissioned service model to a more bespoke patient needs based approach. He explained that EASC was intending to move to a more bespoke transfer and discharge service with WAST but not necessarily with ambulances. Stephen Harrhy agreed to involve the Trust in this work going forward. In answer to a query raised in relation to EMS outbound journeys, Stephen Harrhy confirmed that the data displayed on the slide did not take categorisation into account of the urgency of the calls. EASC would be happy to work with the Trust and WAST in terms of the consistent clear representation of this data going forwards. Prof Donna Mead advised that the Trust had increased the option for virtual patient consultations, where appropriate, instead of patients attending outpatients in the Velindre Cancer Centre. This would have had a consequence on the demand activity over the past year and it was hoped that virtual consultations would reduce the need for vehicle journeys. Steve Ham advised that the nature of the service provision would need to drive the patient transport needs and emphasised the importance of the engagement with EASC to ensure the bespoke patient needs are considered without impacting on their wellbeing. The Trust's involvement with the NEPT Group and the one to one conversations with EASC colleagues would be very beneficial in meeting the needs of the patients. Stephen Harrhy welcomed the Trust's involvement and engagement in this work going forward.	

	Prof Donna Mead queried the route for complaints for patient transport. Stephen Harrhy clarified that EASC do monitor complaints but that it was an exception to receive a complaint from a Velindre patient. It was emphasised that neither party should wait for complaints to act and that there was a need to link into the patient experience mechanisms to influence provision in the future. Prof Donna Mead thanked Stephen Harrhy, Dr Chris Turner and Richard Baxter for the useful presentation and the invitation for both the Trust and EASC teams to discuss the arrangement of bespoke transport services. She confirmed that the Trust would take up the offer to meet with EASC colleagues to assist with keeping the momentum going forward with the transformation of patient transport services. Stephen Harrhy thanked the Trust Board for their helpful feedback and looked forward to working with the Trust to make improvements. Prof Donna Mead thanked Stephen Harrhy, Dr Chris Turner and Richard Baxter for attending. Stephen Harrhy, Dr Chris Turner and Richard Baxter left the meeting.	
3.0.0	**CONSENT ITEMS**	
3.1.0	**FOR APPROVAL**	
3.1.1	**Minutes from the Public Trust Board meeting held on the 30 September 2021** The Trust Board **APPROVED** the Minutes of the meeting held on the 30 September 2021 were an accurate and true reflection.	
3.1.2	**Chair's Urgent Actions Report** The Trust Board **CONSIDERED** and **ENDORSED** the Chairs Urgent Actions taken between the 18 September 2021 – 15 November 2021.	
3.1.3	**Commitment of Expenditure Exceeding Chief Executive's Limit** The Trust Board **AUTHORISED** the Chief Executive to **APPROVE** the award of contracts detailed in Appendices 1-7; and **AUTHORISED** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreements.	

3.1.4	**Revisions to NHS Wales Shared Services Partnership (NWSSP) Standing Orders** Gareth Jones removed this item from the Consent agenda for the following reason:	

	"A point of detail regarding the proposed amendment of subsection 4.8.4 in the NWSSP Standing Orders. The proposed amendment changes the governance and operating framework from the Trust to NWSSP". Gareth Jones clarified that as NWSSP is a hosted organisation, the Governance Framework is set by Velindre University NHS Trust as the host organisation and the Operating Framework is set by NWSSP as the hosted organisation. As such, the amendment needs to be revised to reflect the accountability of the Joint Chairs of the Local Partnership Forum for these two distinct areas. The Trust Board **APPROVED** the amendments to the NWSSP Standing Orders, subject to the amendment to subsection 4.8.4 as detailed above.	
3.2.0	**FOR NOTING**	
3.2.1	**Emergency Ambulance Services Joint Committee Briefing for meeting held on 9 November 2021** The Trust Board **NOTED** the contents of the Emergency Ambulance Services Committee Summary Briefing for the meeting held on 9 November 2021.	
4.0.0	**MATTERS ARISING**	
4.1.0	**Action Log** Prof Donna Mead took the Trust Board through the action log and it was agreed that: • Item **8.1.0** Private Patient Debts – Due to the ongoing reviews being undertaken at the Audit Committee, it was agreed that this action would be **closed**. Updates to be brought back to the Trust Board as appropriate via the Audit Committee Highlight Report. • Item **7.5** Clinical Oncology Strategic Targets (COST) – It was confirmed that the action regarding the development of the electronic data collection for COST had been completed earlier than anticipated and was included in the meeting papers. It was agreed that this action would be **closed**. The Trust Board **APPROVED** the Action Log and the updates captured in the meeting.	

5.0.0	KEY REPORTS	
5.1.0	**Chairs Update** In presenting the Chair's update, Prof Donna Mead reflected on how busy the organisation and its staff were and this was testament to the number of items included within her update report on activities that had taken place since the last Trust Board meeting. Prof Donna Mead was particularly pleased and proud with the launch of the Component Development Research Laboratory (CDRL) and suggested that Trust Board Members view the recordings from the launch event. There were a number of presentations and, in particular, one of interest was the new approaches to optimising storage and function of donated platelets, which had developed from a 'proof in principle' to a 'proof in practice'. Prof Donna Mead advised that she would be attending a socially distanced tour of the CDRL on 2 December 2021 and welcomed other members of the Trust Board to join her if they were able. The following items were also highlighted by Prof Donna Mead as part of her update: • Armistice Day was marked on 11 November 2021 at the Velindre Cancer Centre and was very well attended. • The Therapy Assessment Unit Team at the VCC was nominated and shortlisted for the Macmillan Professionals Excellence Award; • The airing of the BBC Programme 'Dom Delivers', which showcased the work of the Welsh Blood Service and the blood donation journey from the donor's home to the point it is issued to one of the hospitals the WBS service; • Congratulations were extended to Dr Mererid Evans on her appointment as the Director of the Wales Cancer Research Centre; • Congratulations were extended to Nicola Williams on a successful Nursing, Allied Health Professional (AHP) and Clinical/Healthcare Scientists Research Celebration Event held on 12 October 2021. This was well attended with Professor Bridget Johnson, Clinical Professor at University of Glasgow and NHS Greater Glasgow and Clyde as the guest speaker. • The Trust has for several years sponsored the Royal College of Nursing (RCN) Nurse of the Year Award. The RCN Awards Event took place on 10 November 2021. Congratulations were extended to Diane Rees, VCC Navigator who was the winner of the Health Care Support Worker Award. • Of note was the achievement of the Junior Ambassadors during the Pandemic who had between them raised £45,000. To mark this achievement the children and teenagers involved attended a presentation event on 15 November 2021 held at SupaJump and attended by Sam Warburton, Charity Ambassador. Prof Donna Mead confirmed that her Full Year Appraisal Review for 2020/21 had been undertaken and that she had received confirmation	

	that all objectives had been met. She wished to extend her thanks to the Trust's Executive Leadership Team and Trust Officers for their hard work in the collective achievement of her meeting her objectives. In answer to a query raised regarding any change in approach and emphasis by the new Minister compared to the former Minister, Prof Donna Mead advised that her new objectives had not been set yet by the new Minister. However, once her new objectives had been finalised and agreed with the Minister, they would be circulated to the Independent Members. The Trust Board **NOTED** the content of the update report.	
ACTION	Prof Donna Mead to circulate her new objectives to the Independent Members once finalised and agreed with the Minister.	**DM**
5.2.0	**Chief Executive Officer (CEO) Update** Steve Ham provided a summary of his update and the following points were noted: • The hearing to review the decision to refuse an application seeking permission to Judicially Review the process for the Welsh Government's approval of the Outline Business Case for the new Velindre Cancer Centre has dismissed the appeal with the original decision upheld. However, there was still the consideration of the Aarhus Convention for the costs and this would be considered by the judge in the coming months. The Trust has provided its response in this regard. • Cath O'Brien was welcomed to her first meeting following her permanent appointment as Chief Operating Officer. • Following the public and media interest relating to the scrub clearing enabling works for the new Velindre Cancer Centre, which took place at the end of October 2021, members of the Executive Leadership Team and Project Team will be meeting with key stakeholders and community groups to gain feedback and share the learning in order to adapt the approach to future works on the Northern Meadow site. The Trust Board **NOTED** the content of the update.	
6.0.0	**QUALITY, SAFETY & PERFORMANCE**	
6.1.0	**Quality, Safety & Performance Committee Highlight Report** Stephen Harries welcomed Vicky Morris who would be taking up the role as Chair of the Quality, Safety & Performance Committee. In presenting the report, Stephen Harries reflected on the emerging benefits of the changes to the Committee in relation to the triangulation and understanding of the Trust's performance. It was emphasised that a lot of business had been transacted in this Committee meeting and the following key points were highlighted:	

	• **Alert/ Escalation:** The Committee had a lengthy discussion in order to understand the position against the radiotherapy targets, following concern raised. Enhanced Business Continuity measures were now in place to address this and other matters with management through Silver Command. • **Advise:** The Committee had viewed in advance of the meeting a Welsh Blood Service Donor Improvement Story which provided an update on the measures and improvements being implemented to prevent donors who do not meet the strict criteria from booking online. The improvements would prevent potential donors having a wasted journey if unable to donate, avoid disruption to clinics, and free up appointments to eligible donors ensuring the best possible experience for donors. The annual national Medical Engagement Survey was considered, and further engagement work was being undertaken by the Trust to explore the emerging themes with a number of events planned to take place in the coming months. Following the Committee's discussion of the performance reports, Stephen Allen had raised with the Committee a few issues from the patient and public perspective regarding the VCC performance report. There was recognition that there was a need to undertake more engagement work with the Community Health Council in the development of the Trust's Performance Management Framework before it was finalised. • **Assure**: Assurance was received by the Committee that the CIVAS@IP5 (a Shared Services delivered medicines preparation service) had been inspected on 6 September 2021 by the Medicines and Healthcare products Regulatory Agency (MHRA) against Good Distribution Practice. No critical or major service deficiencies were noted in the inspection report and that all action points identified had been completed. Full compliance against the framework of standards legally required as an MHRA "Specials" and Wholesale Dealer licence holder has since been confirmed and a renewed medicines licence has been received. The Committee was pleased with the positive feedback received from the 15 Step Challenge visit undertaken within the Apheresis Clinic at the Welsh Blood Service. A small number of recommendations had been made which would strengthen the inclusivity of services. The Annual Estates update had highlighted a significant increase in gas consumption in the Welsh Blood Service during April 2020 however, following a review this was identified because of changes to the ventilation system as a result of	

	COVID-19. The necessary adjustments to the control have been made to alleviate this. The Patient and Donor Experience Annual Report for 2020/21 brings together all the different sources of feedback and was reflective of the enormous achievements of staff and colleagues over the 12-month period, particularly in relation to the transformation of service delivery. There were many positive aspects highlighted but also some negative aspects, which would be areas for improvement. The Committee agreed that the Annual Report would be scheduled for much earlier in the business cycle for 2021/22. The Committee endorsed the Quality, Safety and Performance Committee Annual Report for 2021/21, which included the Committee Effectiveness Survey Findings, for Trust Board approval. Prof Donna Mead commented that it was a helpful report and that a lot of business was conducted through the Committee. In reading the Patient and Donor Experience Annual Report, Prof Donna Mead acknowledged that several issues over the past year had been addressed and were included within the report. She welcomed the spirit of openness in the report and thanked Nicola Williams and Dr Jacinta Abraham. Stephen Allen advised that he was arranging a meeting with Cath O'Brien to address the areas highlighted within the report. Martin Veale commended the sentiment of the Patient and Donor Experience Annual Report particularly the triangulation of information and what had been achieved in the heart of the Pandemic. As a donor, he was pleased with the messaging around donations and the status of travel as essential. Nicola Williams reflected that it was very helpful to receive the feedback, which helped to address any issues or concerns. She explained that the Committee had raised a number of concerns regarding the volume of Committee papers and the length of reports. Several actions were being taken forward with colleagues to provide report writing training for report authors and a review of the Committee Cycle of Business. Hilary Jones highlighted that the whole patient and donor experience survey as an appendix had not been included with the papers. Nicola Williams advised that the Annual Report was being translated before it could be published on the Trust's website. It was agreed to circulate the full report and appendices following Welsh translation. Prof Donna Mead welcomed the balanced reporting of the concerns and compliments.	

	The Trust Board: • **NOTED** the key deliberations and highlights from the Quality, Safety & Performance Committee held on the 18th November 2021. • **APPROVED** the Patient and Donor Experience Annual Report 2020/21 for publication on the Trust's website; • **ENDORSED** the approach for patient and donor experience going forward; • **APPROVED** the Quality, Safety & Performance Committee Annual Report for 2020-2021.	
ACTION	Nicola Williams to circulate the full patient and donor experience survey following Welsh translation to Independent Members.	**NW**
6.2.0	**BREAK 11:30 - 11:40**	
6.3.0	**Delivering Excellence Performance Report Period September 2021** Cath O'Brien advised that following the detailed discussion at the Quality, Safety & Performance Committee, there was recognition that more developmental work was required to improve how the Trust reflected its performance position in its reporting and the work required to improve the narrative to set the context and reflect the variations in performance. Cath O'Brien advised that there were some challenges in meeting some of the Radiotherapy waiting times targets, the Trust was now reporting against two sets of targets – the Royal College of Radiologists (RCR) targets and those mandated by Welsh Government to also report against the Clinical Oncology Sub Committee (COSC) targets. The latter targets aligned more closely with the direction of travel for reporting against the Single Cancer Pathway. Compliance against the COSC targets was low however, the Trust COSC Improvement Group in Radiotherapy has developed a plan outlining their approach with specific actions and timelines to carry out changes to the patient pathway to support target compliance. It was emphasised that this did not mean that patients were waiting any longer than they were previously under the RCR targets, only that there have been changes in the way patients are categorised. The Trust continues to report against both measures for comparison at present and will continue to do so until the end of the financial year. It was clarified that there was no extra funding support to meet the new stringent COSC targets as it was expected that the Trust would take this forward as part of continuous improvement cycles and service redesign. Although standardisation of the targets will help across all cancer centres. The Finance Team has helped in the conversations with the Commissioners. The Trust was in the same position as other cancer centres with the Cancer Network providing support to the Trust in this regard. The Trust was experiencing a dip in performance in a number of areas linked to the impact of COVID, the reasons for which were multifaceted and complex causing increased pressure on service delivery and	

	staffing resource with staff absences increasing due to the circulation of COVID in the general population. Activity was returning to 95% pre pandemic levels, although there were differing patterns of patient presentations. The Trust continues to work with the Welsh Government's Delivery Support Unit as patient pathways in Health Boards were more of challenge due to the reductions in surgery and a patient's first presentation being in radiotherapy. Infection prevention and control measures has reduced capacity within the VCC by 25%. There have been several breakdowns with the LINAC fleet due to aging equipment that has resulted in a reduction of activity. The Trust has outsourced LINAC capacity with the Rutherford Cancer Centre (RCC) in Newport to supplement and enhance provision to increase capacity to help meet the activity gap. Hyper fractionation was increasing the burden on Medical Physics. Andrew Westwell queried whether the RCC was a viable solution to relieve the short-term pressure. Cath O'Brien clarified that the Trust had a contract to outsource a limited number of slots and was ensuring that appropriate patients were being referred however, the RCC was also having capacity issues with Medical Physics. The Trust was working with the RCC to increase capacity without impacting on the system elsewhere. A number of management intervention escalations were in place to expedite matters such as recruitment, the aging LINAC fleet and other system challenges and difficulties. With the medium to longer term challenges being addressed through the Integrated Medium-Term Plan (IMTP) process. In answer to a query raised by David Cogan regarding the availability of staff to fill vacancies, Cath O'Brien advised that there was a national shortage within the NHS workforce for specialist professions. The complexity of tasks such as 3D plans required enhanced training for staff and increased training requirements for changing treatment approaches. David Cogan asked whether a patient's personal choice to delay treatment was factored into the performance reporting. Cath O'Brien clarified that should a patient choose to delay treatment for whatever reason, the impact of patient choice was not factored into the Trust reporting. Jacinta Abraham advised that there are many more options for the treatment of patients, and this was a success for Oncology. However, sometimes patient treatment pathways change following scanning. The number of palliative patients was increasing and, moving a patient from simple scanning to 3D plans does impact on timescales and compliance with performance targets. Martin Veale asked about staff shortages, particularly related to the specialist professions, and whether the Trust was part of an NHS workforce pipeline initiative. Cath O'Brien advised that the Trust was continually reviewing its workforce planning with the Workforce Team	

	and exploring the medium and longer-term plan options. The Trust was investing in a dedicated Workforce Planner to work with the Trust as part of the Velindre Futures planning. Currently, the Trust was dealing with the immediate needs with an eye on the longer-term requirements. Nicola Williams advised that there was a lead in time of circa 3-5 years to train appropriate professions. The Trust was engaging with Health Education & Improvement Wales (HEIW) and nationally for the future workforce pipeline and exploring growing its own workforce with initiatives such as apprenticeships, student streamlining, etc. A recruitment model was being developed to ensure the longer-term pipeline of specialist staff. Sarah Morley confirmed that the Trust was part of the national discussions relating to the workforce supply issue for the short-term pressures. A Workforce Summit was due to be held the following week with the Welsh Government and others. The Trust was working with HEIW to explore alternative pathways and approaches to attract staff into the NHS. Gareth Jones asked whether there were any other consequences of not achieving the performance targets apart from the impact on patients. Cath O'Brien advised that the Trust reports the performance data into Welsh Government which was discussed as part of the Trust's performance reviews. Welsh Government was fully aware of the ongoing challenges and service pressures for the Trust and was providing support from the Delivery Unit. It was highlighted that the ongoing service pressures were impacting on staff morale and wellbeing. Steve Ham acknowledged the pressure in the system and the need to continue to provide support to all staff in terms of managing their health and wellbeing. Jacinta Abraham advised that there was an impact on clinicians due to the constant pressure and work demands, which was affecting their ability to undertake research studies. This could impact on the Trust's reputation. Stephen Harries emphasised the need for triangulation of the information in relation to key challenges and solutions and the importance of linking it back to other measures such as patient, donor and family experiences. Prof Donna Mead asked about Brachytherapy and whether a business case could be submitted to the Welsh Health Specialist Services Joint Committee for support. Cath O'Brien confirmed that the Trust was developing a business case and would update Prof Donna Mead outside of the meeting and would provide an update at the next Trust Board meeting. Stephen Allen raised the matter of the complexity of the information that was being presented in the report and explained that if the Trust	

	Board attendees were having difficulties reading the report, this would also include members of the public who were less familiar with the content. It was important to show how issues were being addressed in the narrative of the report. Prof Donna Mead proposed that the report narrative be enhanced to set the context for a member of the public to better understand the information that was being presented and focussed through the lens of mitigating clinical risk and patient harm. Gareth Jones questioned whether the current set of circumstances, as a result of COVID, could have been foreseen and whether they could be avoided in future. Cath O'Brien advised that the Trust has been closely monitoring the activity coming through from Health Boards however, the COVID restrictions has created an additional complexity to patient presentations from Health Boards and that coupled with aging equipment has exacerbated the position. Cath O'Brien provided an overview of the Welsh Blood Service (WBS) performance report and confirmed that it was continuing to meet all of the demand whilst maintaining adequate stock levels. The challenge of high donor 'did not attend' (DNA) rates at blood collections was being addressed by donor engagement ahead of the Christmas period. Nicola Williams advised that the Trust was working to address the staffing issues highlighted within Manufacturing Productivity as part of the ongoing recruitment and retention workforce plans. The Trust Board noted the context in which the report was presented and was pleased that WBS was able to help other countries with blood stock demand. The improvement actions in place to address the areas of reduced performance highlighted with the report were also noted. Sarah Morley provided an overview of the Workforce metrics and the following points were noted: • Overall sickness absence rate continues to increase with October 2021 at 5.43%. • Seven staff on COVID absence however, there was a wider focus on wellbeing with a third of the absences were attributed to stress. • In terms of addressing the wellbeing of staff, workforce colleagues are working with managers to address the impact on the wider teams and providing targeted support for hot spot areas with daily COVID surgeries being held in the VCC, management development and wellbeing initiatives for staff. Prof Donna Mead was pleased to note that PADR compliance was on an upward trajectory and asked how the Trust was benchmarking with other organisations, recognising that the Trust was not quite at the required target. Sarah Morley confirmed that the Trust compared very favourable with others across Wales.	

	Stephen Harries provided the Trust Board with assurance that the report had been discussed in detail at the Quality, Safety & Performance Committee on 18 November 2021. The Trust Board **DISCUSSED** and **REVIEWED** the contents of the performance reports and **NOTED** the actions being taken.	
ACTION	Cath O'Brien to update Prof Donna Mead on the development of the WHSSC Brachytherapy Business Case outside of the meeting. Cath O'Brien to provide an update on the WHSSC Brachytherapy Business Case at the January Trust Board.	**COB** **COB**

6.4.0	**Financial Report for the Period Ended 31 October 2021 (M7)**
	
	Matthew Bunce advised the Trust Board that the month 7 financial position had been discussed in detail at the Quality, Safety and Performance Committee on 18 November 2021. This had provided strong assurance regarding the delivery of a balanced year-end financial position.
	
	Matthew Bunce provided an overview of the report and the following points were highlighted:
	
	• The Trust was planning to deliver its capital schemes using two funding opportunities:
	  o The COVID recovery schemes funding would deliver capital schemes which included the ventilation solution at the VCC and donor chairs for the WBS;
	  o Welsh Government slippage monies would be used for digital schemes/equipment as this would ensure expenditure and delivery were successful by the end of the financial year.
	• The overall compliance with the Public Sector Payment Policy (PSPP) was 94.9%, which was just under the 95% target. This was because of a shortage of staff in NWSSP processing the invoices however, the Trust's finance team has been working closely with NWSSP colleagues and achievement of the target was expected this financial year.
	
	Steve Ham advised that the risk of increasing energy costs had been discussed at the Directors of Finance Peer Group and work was ongoing to review the impact across Wales.
	
	In answer to a query raised by Prof Donna Mead regarding any impact during this financial year of increasing energy costs, Matthew Bunce clarified that there would be no impact this financial year However, the impact would be on the energy contract renewal which was in the new financial year 2022/23.
	
	The Trust Board **NOTED** the contents of the month 7 financial report for the period ended 31 October 2021 and, in particular the financial	

	performance to date, and the year-end forecast to achieve financial break-even.	
6.5.0	**Velindre University NHS Trust Risk Register** In presenting the report, Lauren Fear highlighted that the focus of the reporting was on the risks scoring 12 or greater and the ongoing work to refine and enhance the Trust Risk Register. It was highlighted that the Risk Register had been discussed in detail at both the Quality, Safety & Performance Committee and Audit Committee and additional narrative would be included in future reports that outlined the actions being taken to reduce or eliminate the risks. The risk appetite had been discussed at the Audit Committee and it was acknowledged that, in setting risk appetite levels linked to risk scoring, there would need to be regularily review the levels and adjustment as the risk management process matures. Therefore the focus for the next reporting cycle would be on those risks with an impact of 5 regardless of rating to test the scoring process. Lauren Fear provided an overview of the five risks scoring 20, advising that two were related to performance and service sustainability, and three to workforce matters. It was highlighted that one of the five was a new risk and four were rated as 20 in the previous reporting cycle. The following points were highlighted: • ID 14764 (Brexit – Implications of Exiting the EU) and 2401 (Risk of insufficient resources being made available to the Project 3 – Integrated Radiotherapy Solution): The scores were anticipated to reduce following the next review and reassessment of each of the risks; • ID 2400 (Risk that there is lack of project support to Project 5 – Outreach Services): Following review, there have been several system improvement measures implemented and these were expected to mitigate this risk further. Martin Veale highlighted that the programme of work to align all risks to version 14 was progressing well. The controls to manage the risks were shown within the Controls in Place column and this detailed the current position. However, there was a need to include further detail that described the 'who, what and when' to enhance the reporting and mitigations. Gareth Jones supported the comments that had been made in relation to the progress being made however, there were a number of historic dates within the Risk Register that would need to be reviewed as part of the ongoing reassessment of the risks. Lauren Fear highlighted that the main advantage of using a unified Risk Register for the Trust was to enable transparency with everyone being able to access and report via the DATIX system. Although, the	

	challenge would be in the quality of the information however, it was recognised that this was the right approach and there were already benefits evident. Prof Donna Mead acknowledged that the Trust was on a journey in relation to the achievement of a unified Trust Risk Register that was both accurate and reflective of the current position. The Trust Board recognised that this was 'work in progress' and would continue to be refined over the coming months to enable a more ubiquitous way to report. The Trust Board: • **NOTED** the risks assessed at levels 20, 16, 15 and 12 reported in the Trust Risk Register. • **SCRUTINISED** the data in the risk registers including, risk ratings, review dates and identified controls. • **SUPPORTED** the continued work being undertaken on the management of risks in the organisation, which included the ongoing validation, authentication and mitigation of risks. • **NOTED** that a project plan was in place and actions undertaken to expedite progress in establishing a consolidated risk process for the Trust.	
6.6.0	**Velindre University NHS Trust Clinical Audit Report 2020/21** Dr Jacinta Abraham advised that the Trust Clinical Audit Report for 2020/21 had been considered at both the Quality, Safety & Performance Committee and Audit Committee and had been endorsed for Trust Board approval. In presenting the report, Dr Jacinta Abraham was pleased that, despite the Pandemic, a significant amount of audit work had been undertaken and was clearly demonstrated within the report. She acknowledged that the appointment of the two clinical leads; Zoe Gibson and Catherine Pembroke and their contributions, had helped evolve clinical audit within the Trust. Dr Jacinta Abraham highlighted the ambition for clinical audit to be strengthened through the National Quality and Safety Framework and the National Clinical Framework. This would provide assurance that clinical audit remained a high priority, being undertaken within the principles set out in the Trust's Audit Plan and ensuring that continued high quality care was being delivered through the cycles of clinical audit. Prof Donna Mead made reference to 'Key points that need addressing' on page 5 of the report and how these would be actioned. Dr Jacinta Abraham explained that these were the views of the report author, although some quality improvement work had already commenced within Grand Rounds and surveys. However, further education as part of the training for students and trainees would equip them with the	

	necessary core principles and skill sets to enable participation on their clinical journeys. Going forward this would form part of the induction process to ensure a more systematic approach. In response to a query raised in relation to participant feedback, it was clarified that the clinical audit process involved relevant areas for obtaining patient feedback. At a national level, Dr Jacinta Abraham highlighted that the Trust was participating in the UK Coronavirus Cancer Monitoring Project and the UK COVID Radiotherapy Project which were seeking to understand the impact of the pandemic on Cancer outcomes. The report was anticipated in the year. However, it was noted that the Trust only received UK data that was rarely broken down by nation. The Chief Medical Officer was aware and raising at national level. In terms of Artificial Intelligence (AI) Platforms, it was highlighted that the Trust had recently welcomed a PhD student who would be exploring AI and digitisation of patient outcomes/feedback. Prof Donna Mead queried the capacity within the Trust for the analysis and business intelligence (BI) mechanism. Martin Veale advised that Audit Wales have a BI team in their Cardiff office and are looking for improvement projects in Wales. He suggested that the Trust engage with them to assist and to contribute nationally. Martin Veale requested that the Audit Committee be briefed more regularly on the clinical audit plan in order to understand how it fits into the wider audit work. The Trust Board: • **APPROVED** the Trust's Clinical Audit Report 2020/21 • **SUPPORTED** the Clinical Audit function.	
ACTION	Regular Clinical Audit Plan updates to be scheduled into the Audit Committee Annual Cycle of Business.	**JA**
7.0.0	**STRATEGIC DEVELOPMENT**	
7.1.0	**Equality Ambassadors Showcase: Religion & Belief** Sarah Morley reminded the Trust Board that following the publication of the Trust's Strategic Equality Objectives, a renewed commitment was made to ensure greater scrutiny and ownership of the equality, diversity and inclusion agenda across all aspects of the Trusts work. Members of the Executive Team had agreed to take on a role of 'Equality Ambassador', requiring each Executive to align themselves with one of the protected characteristics. Sarah Morley provided a presentation that explored religion and belief and what it meant as the Equality Ambassador for the Trust. The current Trust toolkit for wellbeing in relation to religion and belief included:	

	▪ VCC Multi-Faith Room ▪ Ability to draw on a team of Chaplains representing wide range of denominations and faiths ▪ Work closely with Palliative Care Team ▪ Education for staff on spiritual care ▪ Training to talk to people going through what may be the most difficult time of their life Sarah Morley had liaised with the Trust Chaplain to gain an understanding of what the Trust offer was in respect of religion and belief, considering that people seek out this support when they cannot speak to others. The multi faith service offers support to all patients. Sarah Morley shared her reflection during this work about faith having a different meaning for everyone and that it was important to understand the importance of faith for different people in various situations. A proactive approach to faith was important as was recognising intersectionality. It was also important for Executive colleagues to be a visible ally supporting patients, donors and colleagues. It was recognised that the Trust needed to: • Continue to gain greater knowledge to be able to support with confidence; • Engage with staff to ask how they can be better supported with their religious needs; • Engage with patients and their families to understand what else the Trust needs to do, particularly regarding end of life. Prof Donna Mead advised that it was important to explore what was spiritually important for patients in health and, particularly in a time of illness. However, it was recognised that for blood donors the focus would be different. She explained that a European Group was developing spiritual competencies and that Prof Linda Ross was the project lead from a UK perspective. Prof Donna Mead agreed to make contact with Prof Linda Ross regarding the progress in the development of spiritual competencies across this aspect. Martin Veale commented that the presentation had been helpful and recognised that each of the characteristics did overlap. He emphasised the need for tolerance, respect, and the appropriateness of responses, particularly when strong beliefs clash or where others might not agree. It was recognised that the Christian calendar was the predominant focus within the UK however, it was important at special times of the year for other faiths and cultures, to support our patients/donors at these times. It was highlighted that the Trust Chaplain works across all the different faiths and all are included in her embrace. Steve Ham acknowledged that there were a number of emerging themes from this that need to be explored further such as	

	intersectionality. Sarah Morley advised that an Equality, Diversity and Inclusion Development Programme has been developed for 2022 onward that would help to triangulate in the drive forward. The Trust Board **NOTED** the presentation detailing the work to date and looked forward to seeing how the equality, diversity and inclusion work develops.	
ACTION	Prof Donna Mead to contact Prof Linda Ross regarding the work of the European Group in the development of spiritual competencies.	**DM**
7.2.0	**Strategic Development Committee Highlight Report** Stephen Harries presented the highlight report from the Strategic Development Committee held on 8 November 2021 and the following points were noted: • Welsh Government Capital funding has been made available to support seven Trust COVID recovery schemes; • A presentation by the Collaborative Cancer Leadership Group on Developing the Cancer Systems for South East Wales was received by the Committee that updated on the work that was exploring the Trust's role in patient outcomes in regional and national pathways. A facilitated workshop was being planned for January 2022. The Trust Board **NOTED** the contents of the report and actions being taken.	

7.3.0	**Transforming Cancer Services Programme Scrutiny Sub-Committee Highlight Reports for meetings held on 21 September 2021 and 25 October 2021**
	
	Stephen Harries presented the highlight reports of the Transforming Cancer Services Programme Scrutiny Committee meetings held on 21 September 2021 and 25 October 2021. The following points were noted:
	
	• 21 September 2021
	  ○ The projected revenue year-end overspend of £30k was discussed and how this would be managed.
	  ○ The IRS capital forecast has been added as a new risk due to a projected year-end capital overspend. Meetings have been arranged to explore how that would be managed.
	  ○ An update on progress against the Nuffield Recommendations was received and noted.
	
	• 25 October 2021
	  ○ The projected revenue year-end overspend has reduced to £17K however, there was still a projected year-end capital overspend for IRS. The latter was to be managed within the wider Transforming Cancer Services Programme.	

	The Trust Board **NOTED** the contents of the report and actions being taken.	
7.4.0	**Transforming Cancer Services Communication & Engagement Update** Lauren Fear provided an update on the programme of communications and engagement for the Transforming Cancer Services Programme during the period of mid-October to mid November 2021. The following points were noted: • Focus on continued engagement and communications to support the competitive dialogue process; • Strategic counsel and operational communications and engagement activity to support ground survey works; • Working with partners to progress the regional workstreams; • Updating FAQs and Myth Busting campaign. The Trust Board **NOTED** the report and considerable amount of work undertaken.	
8.0.0	**INTEGRATED GOVERNANCE**	
8.1.0	**Audit Committee Highlight Report** Martin Veale presented the highlight report for the Audit Committee held on 14 October 2021 and the following points were noted: • Audit Wales presented the Financial Audit Report 2020/21 which was a positive report, given the issues surrounding the stocktake last year. Two recommendations have been accepted by management and have been implemented. • Five Internal Audit Reports were received, all received a 'Reasonable' Assurance rating with no major issues highlighted. • Counter Fraud reporting showed that two investigations had been closed with one active investigation ongoing. • Due to the early retirement of the Counter Fraud Manager, a recruitment campaign was ongoing for an Investigator to provide more capacity within the Counter Fraud Team in order to provide the Trust with an appropriate level of support. The Trust Board **NOTED** the contents of the report and actions being taken.	
8.2.0	**Charitable Funds Committee Highlight Report** Prof Donna Mead presented the highlight report for the Charitable Funds Committee held on 4 November 2021. The following points were noted: • The view from a fundraiser's perspective was a regular item on the Committee agenda, which provided an opportunity for	

	fundraisers to showcase to the Committee their experiences of how they raise funds; • Following the impact of COVID, fundraising has improved with a busy schedule in November 2021; • Appointment of an Interim Head of Fundraising and the implementation of a comprehensive training and development programme for the fundraising team. • Charitable Funds Trustees Annual Report for 2020/21 to be presented as part of the Fundraising Annual Event planned for January 2022 which all Trust Board members would be invited to; • Annual Accounts for 2021 to be presented at an Extraordinary Committee meeting on 22 December 2021 together with the Trustees Annual Report; • Funding was approved for a further two years for the Advanced International Fellowship Programme Medical Training Initiative. Whilst it provided opportunities for overseas medical staff to facilitate the experience and development opportunities as they contribute to education and research in the NHS, as well as developing their own practice, there was a need to explore ways of becoming self-funding and the need for an exit strategy at the end of this funding cycle; • Business Case Expenditure Evaluation Annual Reports were received for two funding initiatives, which were required at the end of each funding year and at the end of the funding to assure the Committee that projects were being undertaken as per the approvals. It was highlighted that the content of the reports was improving. The Trust Board **NOTED** the contents of the report and actions being taken.	
8.3.0	**Blaenavon Data Centre Transition Project** Stuart Morris joined the Trust Board meeting. Prof Donna Mead welcomed Stuart Morris to his last meeting of the Trust Board before he leaves the Trust for promotion. The Trust Board extended its huge thanks to Stuart Morris for his hard work and support during his employment in the Trust and wished him all the very best in his new role. Stuart Morris thanked the Trust Board and colleagues for their kind wishes. He acknowledged that it was a big career step but was looking forward to the new opportunity. In presenting the report, Stuart Morris confirmed that the nine-week migration of the national IT services and associated infrastructure out of the Blaenavon Data Centre (BDC) into a new facility in South Wales had been successfully completed. He commended colleagues from Digital Health & Care Wales (DHCW) who had managed the process, kept to the plan, albeit with some changes, and had maintained	

	excellent support and communication with the Trust's Digital Services Team during the whole process. Stuart Morris raised concerns regarding the Velindre Cancer Centre (VCC) and CANISC (Cancer Information System Cymru). Whilst there was now a resilient Service, the CANISC risk was still there until the transition away from CANISC in 2022. Stephen Harries commended the robust information governance aspects that had helped to protect the confidentiality of patient and donor information during this complex process. The Trust Board welcomed the very smooth transition which had been delivered to time and wished to formally record it's gratitude to DHCW for their well managed process.split infinitive. Should be wished to record formally. The Trust Board **NOTED** the report.	
9.0.0	**ANY OTHER BUSINESS** There were no further items for discussion.	
10.0.0	**DATE AND TIME OF THE NEXT MEETINGS** • **Board Learning, Development & Briefing Session scheduled for 16 December 2021** It was noted that arrangements for this meeting were being made so that the session could be a face to face meeting for Trust Board members. • **Trust Board** 27 January 2022 at 10:00.	
11.0.0	**CLOSE** The Board was asked to adopt the following resolution: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).	

TRUST BOARD

CHAIRS URGENT ACTION MATTER REPORT

DATE OF MEETING	27/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance and Chief of Staff

REPORT PURPOSE	**CONSIDER** and **ENDORSE**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Board Members – Via Email	20/12/2021	Approved

ACRONYMS	
PPE	Personal Protective Equipment
NWSSP	NHS Wales Shared Services Partnership

1. SITUATION/BACKGROUND

1.1 In accordance with Trust Standing Orders, there may occasionally, be circumstances where decisions, which would normally be made by the Board, need to be taken between scheduled meetings and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and Chief Executive, supported by the Director of Corporate Governance & Chief of Staff, as appropriate, may deal with the matter on behalf of the Board – after first consulting with at least two other Independent Members. The Director of Corporate Governance & Chief of Staff must ensure that any such action is formally

recorded, and reported to the next meeting of the Board for consideration and ratification. Where issues are included in the Schedule of 'Expected Urgent Decisions' and prior approval is sought from the Board, these issues will not be reported here.

1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

1.3 This report details Chair's Urgent Action taken between the **16 November 2021** to the **14 January 2022**.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis:

The items outlined in Appendix 1 have been dealt with by Chairs Urgent Action.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call a Board meeting and to avoid delays that could affect service delivery and quality.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Financial impact was captured within the documentation considered by the Board.

4. RECOMMENDATION

4.1 The Board is asked to **CONSIDER** and **ENDORSE** the Chairs urgent action taken between the **16 November 2021** to the **14 January 2022** as outlined in Appendix 1.

Appendix 1

The following items were dealt with by Chairs Urgent Action:

1. NHS Wales Shared Services Partnership (NWSSP) Reinstatement of Temporary COVID Authorisation Limits

The Trust Board were sent an email on the 20 December 2021, inviting the Board to **APPROVE:**

- Re-instatement of the £5m temporary delegated authority limit for COVID-related expenditure for the Chair and Managing Director of NWSSP to the end of June 2022.

- Re-establishment of the NWSSP Finance Governance Group noting that the associated Terms of Reference be updated to reflect the recent appointment of Matthew Bunce as the new Executive Director of Finance, replacing Mark Osland.

- The Trust Interim Vice-Chair, Stephen Harries reassume his role on the NWSSP Financial Governance Group to support Trust oversight and scrutiny of NWSSP procurement requests in response to COVID 19 PPE requirements. Due to the role proposed to be reassumed by the Interim Vice-Chair on this group, it should be noted that the Vice-Chair abstained from this approval request.

Due to the urgency of this matter, it could not wait until the January 2022 Trust Board meeting.

Recommendation Approved:

- Professor Donna Mead, Chair
- Steve Ham, Chief Executive Officer
- Hilary Jones, Independent Member
- Vicky Morris, Independent Member
- Professor Andrew Westwell, Independent Member
- Sarah Morley Executive Director of Organisational Development & Workforce

No objections to approval were received.

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENT OF EXPENDITURE EXCEEDING £100K FOR THE PERIOD 27 January 2022 to 31 March 2022

DATE OF MEETING	27 January 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable – Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	For **APPROVAL**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Capital Planning Group ***(Appendices 1-2)***	18/01/2022	Supported
Executive Management Board 'Shape' ***(Appendices 1-2)***	18/01/2022	Endorsed for Board Approval
Executive Management Board 'Run' ***(Appendices 3-4)***	04/01/2022	Endorsed for Board Approval

ACRONYMS	
SFIs	Standing Financial Instructions
VCC	Velindre Cancer Centre
VUNHST	Velindre University NHS Trust

1. SITUATION/BACKGROUND

1.1 Velindre University NHS Trust (VUNHST) has a Scheme of Delegation, as set out in its Standing Orders, together with its Standing Financial Instructions (SFIs), which ensures that there are effective governance arrangements in place for the delegation of financial authority.

1.2 Financial limits apply to the commitment of expenditure. If expenditure is greater than an individual's financial limit, and is more than the limit delegated to the VUNHST Chief Executive, the planned expenditure will require VUNHST Board approval. For extensions of existing contracts in place, this only applies if the provision for extension was not included in the original approval granted by the Trust Board.

1.3 The decisions expected during the period **27 January 2022 to 31 March 2022** are highlighted in this report and are seeking approval for the Chief Executive to authorise approval outside of the Trust Board.

1.4 In line with the review of the process for Commitment of Expenditure over the Chief Executive's Limit, all reports are now received by the Executive Management Board to ensure Executive oversight and scrutiny, to provide the Board with supporting recommendations and additional assurance as required.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Please refer to **Appendices 1 - 4** for the detailed appraisals undertaken of each of the expenditure proposals that the Trust Board is asked to **APPROVE**. The table below provides a summary of the decisions being sought from the Trust Board:

Appendix No.	Division	Scheme / Contract Agreement Title	Period of Contract	Total Expected Maximum Value of Contract £ (Inc. VAT)
Appendix 1	Corporate Estates, Environment and Capital	Capital Programme – Support: Professional Services Appointment	Start: 10/02/2022 End: 31/03/2022 Option to extend: n/a	£174,000
Appendix 2	Corporate Estates, Environment and Capital	Velindre University NHS Trust – Emergency Lighting	Start: 30/02/2022 End: 30/05/2022 Option to extend: n/a	£360,000
Appendix 3	VCC	Extension of Varian Parts Order	Start: 01/03/2022 End: 26/12/2022 Option to extend: n/a	£144,000
Appendix 4	VCC	Varian Multi Leaf Collimators (MLC) Refurbishment	Start: February 2022 End: Option to extend: n/a	£162,000

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Due authority is being sought in advance of expenditure to ensure the compliant provision of goods/services to meet operational requirements.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	Undertaken on a case by case basis, as part of the procurement process.
LEGAL IMPLICATIONS / IMPACT	If applicable, as identified in each case as part of the service design/procurement process.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Further details are provided in Appendix 1 - 4 of this report.

4. RECOMMENDATION

4.1 The Board is requested to **AUTHROISE** the Chief Executive to APPROVE the award of contracts summarised within this paper and supporting appendices and **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement.

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	CAPITAL PROGRAMME - SUPPORT
DIVISION / HOST ORGANISATION	Corporate Estates, Environment and Capital
DATE PREPARED	14/01/2022
PREPARED BY	Jason Hoskins Assistant Director Estates, Environment and Capital
SCHEME SPONSOR	Carl James Director of Strategic Transformation, Planning, and Digital

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Capital Programme - Support

- Estates Department took on an ambitious Capital Programme during 2021/22 to benefit the Trust, delivering a variety of schemes to support compliance of the estates.
- Following resignation of the Capital Programme Manager it was identified that support was required to oversee the management of the Programme
- Procurement have also encountered issues. Estates previously dealt with procurement in house, this changed at the start of 2021 with procurement picking up this aspect of work. Procurement experienced issues through loss of staff through the summer months which although now replaced required bedding in and familiarization of process
- The Capital Programme involves some 23 schemes with an estimated value of circa. £1.5M all in various stages of delivery
- The support services required to deliver the programme of works will be approached in two parts to be procured via one FrameWork – SCAPE Built Environments England/Wales NI (Perfect Circle award), which covers professional services for Project Management/Design Support and Procurement of the Capital Programme.
- The Framework was selected due to the flexibility allowed in support of provision of professional services to support project delivery and promotes appointments task order thus allowing flexibility of approach. In this instance there are two task orders the first covering fees associated with Project Management and Design, the second covering fees associated with procurement of works.

• Task Order 1 - PM and Design Service, Value £95,354 ex Vat • Task Order 2 – Procurement Services, Value £26,959.71 ex VAT						
1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☒	Contract Extension	☐	Contract Renewal	☐

1.2 Period of contract including extension options:	
Expected Start Date of Contract	10/02/2022
Expected End Date of Contract	31/03/2022
Contract Extension Options **(E.g. maximum term in months)**	Further 4 months

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☒
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☐	☒
If not, please explain the reason for this in the space provided. Recent events have seem the resignation of the Capital Programme Manager and resourcing issues within the procurement department. Both have a direct impact on the ability of the Trust to deliver Capital works. The proposed solution is to procure professional services to support the project management design and procurement of the capital schemes under development.		

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☒
Deliver bold solutions to the environmental challenges posed by our activities.	☒
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☒

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☒	Long Term	☒	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Option 1 Do Nothing – This is not an option as the current estates and procurement resource is not available to support delivery of the Capital Programme *Option 2 Recruit New Staff – This is a longer term scenario which doesn't meet current requirements dictated by time dependencies* *Option 3 Procure Professional Support – This is the preferred option as it meets the immediate need and provides a compliant solution.*

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
• The preferred Options to procure professional services has clear benefits over other options considered. • Various routes to market via Framework • This option can be immediate appointment which meets time critical needs • Flexible solution that can be tailored to meet exact requirement • Readily available support No further impact on already under resourced teams

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
• Failure to deliver 2021/22 Capital schemes • H&S issues • Loss of Welsh Government Funding • Impact on staff morale and wellbeing	• Risks cannot be fully mitigated this is a resource issue

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☒
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐

Click here for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy
The procurement strategy to meet the need is to award through Direct Call off Framework SCAPE Built Environments England/Wales NI (Perfect Circle award) which meets the requirements of this appointment and is a tested means for this scenario
6.3 What is the approximate time line for procurement?
Immediate – all necessary paper work has been completed. It is anticipated that two weeks time line be allowed for internal signatories to sign appointment forms

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route

Head of Procurement Name:	Christine Thorne
Signature:	
Date:	18/01/22

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k) £145,000**	**Including VAT (£k) £174,000**
The nature of spend	**Capital** ☒	**Revenue** ☐
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☒ Other ☐		
If you have selected 'Other' – please provide further details below:		

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	**Year 1 (exc. VAT) £k**	**Year 2 (exc. VAT) £k**	**Year 3 (exc. VAT) £k**	**Total Future Years (exc. VAT) £k**	**Total (exc.VAT) £k**	**Total (inc. VAT) £k**
Gleeds Services to Support PM, Design inc contingency	£110,000				£105,000	£132,000
Gleeds Services to Fulfill Procrement inc contingency	£35,000				£35,000	£42,000
Overall Total	£145,000				£145,000	£174,000

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*The management arrangement are via Perfect Circle through the SCAPE Built Environments England/Wales NI frame work and RIBA. This project will be managed against organisational SFI's and the estates project management process.*

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Carl James
Signature:	
Service Area:	Corporate
Date:	14/01/2022

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
Trust Capital Planning Group	18/01/2022
Executive Management Board	18/01/2022

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	VELINDRE TRUST - EMERGENCY LIGHTING
DIVISION / HOST ORGANISATION	Corporate Estates, Environment and Capital
DATE PREPARED	14/01/2022
PREPARED BY	Jason Hoskins Assistant Director Estates, Environment and Capital
SCHEME SPONSOR	Carl James Director of Strategic Transformation, Planning, and Digital

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

- **Replacement of EL Trust wide:**
  - Assessment of the Trust Estates has highlighted a number of issues that present a risk from a fire safety perspective.
  - A business case has been presented to Welsh Government outlining funding requirements to address concerns raised
  - Welsh Government have endorsed the proposal providing £1.1M of funding staged over a number of years in support rectification of the identified issues
  - An external consultancy firm was commissioned to carry out an assessment of the condition of Emergency Lighting across the trust which has informed the approach adopted by the Trust
  - A work package to address issues that exist across the Trust relating to Lighting has been compiled in preparation to go to tender.
  - Rough Order costs associated with scope of works to replace Lighting at VCC cost £300K
  - The works will be approached and delivered through a series of work packages
  - All works have been reviewed and signed off internally by the Trust Fire Safety Manager, and external consultant

1.1 Nature of contract:	First time	☒	Contract Extension	☐	Contract Renewal	☐

Please indicate with a (x) in the relevant box						

1.2 Period of contract including extension options:	
Expected Start Date of Contract	30/02/2022
Expected End Date of Contract	30/05/2022
Contract Extension Options **(E.g. maximum term in months)**	

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐
This scheme has been identified as part of the Estates Compliance Capital works 2021 – 2023. Funding has been secured through Welsh Government.		

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☒
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☒

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED Please mark with a (x) in the box the relevant principles for this scheme. Click **here** for more information									
Prevention	☐	Long Term	☒	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
There are limited options available with the exception of *Option 1 - Do Nothing – presents ongoing H&S risks associated with the non-compliance – Fire Safety legislation and H&S legislation breach* *Option 2 - Supply and install Emergency Lighting, In doing so making the Trust compliant with WHTM and H&S Legislation* *Preferred Option – This options provides a compliant solution reducing risk of fire to life and limb, and property. Underpinned by a full assessment of the Estate.*

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
• Provides a fully auditable compliant solution to asset level including update of the Trust Fire Safety Management documentation, and Bolster system allowing ongoing management of each asset. • Removes all identified risk presented as requiring attention detailed within the commissioned survey and provides a benchmark for future management.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
• Non compliance with WHTM firecode • Non compliance with H&S Legislation • Non compliance with building documentation - The Fire Strategy for buildings	• Risks cannot be fully mitigated

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☒	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐
Click here for link to Procurement Manual for additional guidance			

6.2 Please outline the procurement strategy
Formal procurement exercise to be undertaken via the pending appointment of the Professional Services to be procured via the Built Environment England Wales and Northern Ireland Framework (SCAPE), as presented in a separate paper. **Competition is assured via the subsequent competition ensuring demonstration of value for money.**
6.3 What is the approximate time line for procurement?
6 weeks

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Christine Thorne
Signature:	
Date:	18/01/22

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)**	**Including VAT (£k)**
The nature of spend	**Capital** ☒	**Revenue** ☐
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☐ Additional Welsh Government funding ☒ Other ☐		
If you have selected 'Other' – please provide further details below:		

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	**Year 1 (exc. VAT) £k**	**Year 2 (exc. VAT) £k**	**Year 3 (exc. VAT) £k**	**Total Future Years (exc. VAT) £k**	**Total (exc.VAT) £k**	**Total (inc. VAT) £k**
Emergency Lighting purchase	£115				£115	£138
Labour Costs	£150				£150	£180
Overall Total	£300				£265	£318

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*This project will be managed against organisational SFI's and the estates project management process*

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Carl James
Signature:	
Service Area:	
Date:	18/01/2022

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
Trust Capital Planning Group	18/01/2022
Executive Management Board	18/01/2022

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	EXTENSION OF VARIAN PARTS ORDER
DIVISION / HOST ORGANISATION	Velindre Cancer Centre
DATE PREPARED	1/11/21
PREPARED BY	Claire Power/ Tony Millin
SCHEME SPONSOR	Paul Wilkins

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Velindre University NHS Trust currently has a preventative maintenance agreement with Varian for the period 27th December 2018 – 26th December 2022. This includes support, some routine servicing but, does not include replacement parts

The supply of essential Linear Accelerator replacement parts is required to ensure continued Radiotherapy service delivery in a timely manner. The time taken to complete the paperwork and get approval for these parts adds to the downtime and this is a regular undertaking as few items that require replacement are less than £5K.

This proposal is to establish a call off order with Varian, reducing the need for multiple SQA's and avoiding protracted delays and consequent service downtime. The call off order will incur expenditure on a needs basis, and does not necessarily equate to the full sum proposed.

The spare parts required will be varied in both quantity and cost as these parts fail at irregular intervals. The requested total amount is based on the last 3 years of parts purchased for Varian equipment.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☐	Contract Extension	☒	Contract Renewal	☐

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/03/2022
Expected End Date of Contract	26/12/2022
Contract Extension Options **(E.g. maximum term in months)**	Should Elekta be the successful bidder of the IRS procurement a further extension will be required until the opening of nVCC. Should Varian be the successful bidder maintenance of their machines will be incorporated into that contract.

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☒
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
Yes IRS replacement	☒	☐
If not, please explain the reason for this in the space provided.		
2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.		

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☒
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☒	Long Term	☐	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Linear accelerator is a radiotherapy medical device and as such there are restrictions on what spare / replacement parts can be utilised to ensure the equipment performs to manufacturer's expectations. Do nothing – this will go back to the current situation and introduces delays in ordering supplies of Linear Accelerator parts, in some less urgent cases the STA requires an amendment because the significant delay has resulted in a price increase from the supplier. This option increases down time of the medical equipment which can lead to breaches of national waiting times for Radiotherapy treatments. In house – some items have been sourced from alternative suppliers, however, this is only for a limited number of low value items and as such cannot be used as a reliable alternative for all items.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
• It is anticipated that the proposed arrangement would result in cost savings. In general the replacement parts for Varian equipment are only available from the supplier. Where possible, cheaper alternative suppliers may be used, but this is only the case for a very limited range. The cost saving would derive from the ability to procure parts when required (the full parts (essentials) contract costs, assessed at the time of procurement, was approximately £500K over five years). • It is anticipated that the institution of the proposed arrangement would facilitate more rapid procurement of replacement parts, thereby, reducing machine downtime, maintaining radiotherapy treatment capacity and supporting performance relative to time to radiotherapy targets.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
Machines will be out of action for a longer period of time causing patient delays and breach in waiting times targets.	Senior management will need to be available at all times to ensure swift process of STA paperwork and signatures.

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.	
Competition	**Single source**
3 Quotes ☐	Single Quotation Action ☐
Formal Tender Exercise ☐	Single Tender Action ☒
Mini competition ☐	Direct call off Framework ☐
Find a Tender ☐ (replaces OJEU Public Contract regulations 2015 still apply)	All Wales contract ☐

Click here for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy

A Single Tender Action exercise will be undertaken.

Welsh Government notification will be issued and a VEAT (Voluntary Ex-Ante Transparency) notice will be published (which will require a mandatory 'stand still' period of 10 calendar days).

6.3 What is the approximate time line for procurement?

As noted above (6.2), the publication of a VEAT notice will be accompanied by a 10 calendar day standstill period.

It is anticipated the contract will commence 1st March 2022.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Christine Thorne
Signature:	
Date:	25/01/22

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k) 120K**	**Including VAT (£k) 144K**
The nature of spend	**Capital** ☐	**Revenue** ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☐		
If you have selected 'Other' – please provide further details below:		

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Parts and contingency	120				120	144

Overall Total	120				120	144

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Paul Wilkins
Signature:	
Service Area:	Director of VCC
Date:	10/12/2021

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
Business Planning Group or local equivalent	w/c 13/12/2021 (remotely – Group meetings stood as part of Covid response measures).
Divisional Senior Management Team	23/12/2021
Executive Management Board	04/01/2022

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	VARIAN MLC REFURBISHMENT
DIVISION / HOST ORGANISATION	Velindre Cancer Centre
DATE PREPARED	December 2021
PREPARED BY	Tim Register, Linear Accelerator Maintenance Section Manager and Jeff O'Sullivan, Planning and Performance Manager
SCHEME SPONSOR	PAUL WILKINS, DIRECTOR OF VCC

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Varian Multi-leaf Collimators (MLCs) are used to define the treatment area on patients undergoing radiotherapy. The MLCs have very tight gap tolerances between leaves and a coating that allows for smooth movement is applied during the manufacturing process. The coating on the individual leaves and the carriage box they sit in needs to be replaced periodically. It has been indicated that all of the linear accelerators (linacs) at Velindre Cancer Centre (VCC) would benefit, appreciably, from the refurbishment of MLCs. It is also necessary to replace other parts found to be out of tolerance. Such work would improve performance and reduce instances of machine breakdown.

Varian specify certain tolerance bands for pulse width modulation values of each individual leaf (120 per linac), with a maximum value of 20. Some leaves are now showing values above this and no remedial action taken has reduced the values significantly. It is anticipated that this situation will worsen over time.

A linac is a radiotherapy medical device and as such there are restrictions on what spare / replacement parts can be utilised to ensure that the equipment performs to the manufacturer's expectations. As such, it is recommended that refurbishment kits and parts be procured in order to facilitate the refurbishment of two of the Varian-supplied linacs. Varian engineers will attend the VCC site to carry out the refurbishment works.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☒	Contract Extension	☐	Contract Renewal	☐

1.2 Period of contract including extension options:	
Expected Start Date of Contract	February 2022
Expected End Date of Contract	February 2023
Contract Extension Options **(E.g. maximum term in months)**	

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☒
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐

Maintenance of time-to-radiotherapy performance is a key objective and the maximization of radiotherapy treatment capacity will also support the systematic implementation of the Single Cancer Pathway and the novel time-to radiotherapy targets developed by the Clinical Oncology Sub-Committee (COSC) for use in Welsh cancer centres.

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☒
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☒

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☒	Long Term	☐	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Do nothing – ongoing reactive maintenance cannot preclude regular machine breakdowns. Breakdowns result in poor staff/patient experience. Unplanned periods of linac downtime can negatively impact on treatment capacity potentially resulting in time to radiotherapy breeches.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
• Reduced machine downtime due to breakdown. • Maintenance of radiotherapy treatment capacity.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
More frequent instances of machine breakdown and more extended periods of machine downtime.	• Reactive repair work undertaken by VCC engineering staff. • Extended hours of operation on matched machines to accommodate patients otherwise subject to treatment delays.

6. PROCUREMENT ROUTE

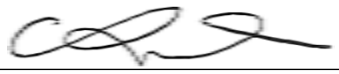
6.1 How is the contract being procured? Please mark with a (x) as relevant.

Competition		Single source	
3 Quotes	☐	Single Quotation Action	☒
Formal Tender Exercise	☐	Single Tender Action	☒
Mini competition	☐	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐

Click here for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy
The kits and parts must be supplied by the machine manufacturer, Varian. A Single Tender Action exercise will be undertaken. Welsh Government notification will be issued and a VEAT (Voluntary Ex-Ante Transparency) notice will be published (which will require a mandatory 'stand still' period of 10 calendar days).
6.3 What is the approximate time line for procurement?
Welsh Government have confirmed the availability of capital monies to undertake the procurement. As noted above (6.2) the publication of a VEAT notice will be accompanied by a 10 calendar day standstill period. Ideally, refurbishment work on the first of the two linacs will take place, following Trust Board approval, in February 2022. The second machine will undergo refurbishment work at a later juncture prior to the end of March 2022. Each refurbishment will be undertaken over a period of approximately two days.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Christine Thorne
Signature:	
Date:	24/01/22

Maximum expected whole life cost	Excluding VAT (£k)	Including VAT (£k)

relating to the award of contract	**£135,000**	**£162,000**
The nature of spend	**Capital** ☒	**Revenue** ☐
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☐ Additional Welsh Government funding ☒ Other ☐		
If you have selected 'Other' – please provide further details below:		

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Cost of refurbishment	£135,00	£0	£0	£0	£135,000	£162,000
Overall Total	£135,000	£0	£0	£0	£135,000	£162,000

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	The refurbishment will be overseen by VCC engineering staff.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Paul Wilkins
Signature:	
Service Area:	Director of VCC
Date:	23/12/2021

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
Business Planning Group or local equivalent	w/c 13/12/2021 (remotely – Group meetings stood as part of Covid response measures).
Divisional Senior Management Team	23/12/2021
Executive Management Board	04/01/2022

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

AMENDMENT TO STANDING ORDERS – SCHEDULE 3

DATE OF MEETING	27/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	01/11/2021	Endorsed for Committee Approval
Charitable Funds Committee	04/11/2021	Endorsed for Board Approval
Strategic Development Committee	08/11/2021	Endorsed for Board Approval

Quality, Safety & Performance Committee	18/11/2021	Endorsed for Board Approval
Audit Committee	11/01/2022	Endorsed for Board Approval

ACRONYMS	
SO	Standing Orders
ToR	Terms of Reference

1. SITUATION

1.1 The Velindre University NHS Trust Standing Orders form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Standards of Behaviour Framework Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

1.2 All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

1.3 The purpose of this report is to outline the required changed to the Trust Standing Orders – Schedule 3, resulting from the Annual Review of the Terms of Reference and Operating Arrangements in respect of the:

- Charitable Funds Committee;
- Strategic Development Committee;
- Quality, Safety & Performance Committee, and
- Audit Committee

1.4 The Trust Board is asked to **APPROVE** the revised Standing Orders – Schedule 3 for the updated Terms of Reference and Operating arrangements for each of the above Trust Board Committees, included in ***Appendices 1 - 4.***

2. BACKGROUND

2.1 In September 2020, the Trust Board approved a new Board Committee model resulting in the move from a top line nine-committee model to a five-committee model effective from November 2020.

2.2 The new Board Committee model introduced a host of key changes to the operating arrangements including the establishment of two new committees, namely the Quality,

Safety & Performance Committee and the Strategic Development Committee. In parallel, it invoked the dissolution of the Quality & Safety Committee, Planning & Performance Committee, Digital & Information Governance Committee and Workforce & Organisational Development Committee, which no longer operate as separate Committees of the Board.

2.3 The revised Board Committee model necessitated a review of all Board Committee Terms of Reference and Operating Arrangements together with the development of new Terms of Reference and Operating Arrangements for the newly established Quality, Safety & Performance Committee and the Strategic Development Committee.

2.4 As such, this review represents the first Annual Review of the Terms of Reference and Operating Arrangements for both the Quality, Safety & Performance Committee and the Strategic Development Committee.

2.5 Also included for endorsement are the updated Terms of Reference and Operating Arrangements of the Charitable Funds Committee and Audit Committee whose normal Annual Review cycle has fallen within this period and as such are also included here for Board Approval.

2.6 This review has also been undertaken against the backdrop of Wave #4 of COVID-19 where the Trust has re-activated its agreed dedicated incident command and control structure on the 15/12/2021. This has necessitated a review of the Board governance structure in light of the changing pressures in managing Wave #4. This has resulted in the following revised arrangements being enacted summarised below:, none of which necessitate a revision to the Standing Orders:

- Again revert to fortnightly Board Briefings – with sections of this time allocated as a formal Public Board or Private Board meeting for decision making as required.
- QSP will be monthly to allow time for further assurance on decisions made through command structure and scrutiny of performance through a quality and safety lens.
- The other committees will run as planned but with streamlined agenda – (exception being TCS given the volume of business still required for scrutiny through the committee over next three months)

It should be noted that the revised arrangements as outlined under 2.6 do not necessitate a temporary revision to the Trust Standing Orders.

3. ASSESSMENT /SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Summary of Amendments

The revised Terms of Reference and Operating Arrangements are set out in **Appendices *1 - 4***, and include the following key changes which are summarised below:

Terms of Reference & Operating Arrangements	**Summary of Amendments**
Quality, Safety & Performance Committee	**Section 2:** - **Purpose** has been strengthened to reflect the Committee's role in respect of scrutiny and assurance of all relevant **statutory** and **regulatory** requirements that sit within the Quality, Safety & Performance remit - Amalgamation of **advice** and **assurance** remit and responsibilities to remove duplication and aid read across **Section 3:** - Addition of Committee's role in promoting and adopting a **triangulated** approach to advise and assurance for the Board - Addition of Committee's remit in ensuring a robust Quality Management System is in place across the Trust and meeting the requirements outlined in the Wales Quality Framework - Inclusion of the Committee's role in considering the implications for patient / donor experience / outcomes, planning and finance - Removal of items of business from the Committee's remit that fall within the agreed remit of either the Executive Management Board / Strategic Development Committee and / Audit Committee, namely: o Commitment of Expenditure over the Chief Executive's Limit (*overseen by EMB*) o Trust Capital Programme & Expenditure (*overseen by EMB &*

Terms of Reference & Operating Arrangements	Summary of Amendments
	Strategic Development Committee) ○ Trust Assurance Framework (*overseen by Strategic Development Committee and Audit Committee*) - Strengthened the Committee's role in respect of ensuring there is an ethos of learning and improvement and its role in ensuring the Health & Care Standards (2015) are applied and met - Addition of the wider governance and accountability reporting arrangements in place at a local and divisional level that feed upwards into the Committee **Section 4:** - Attendance, addition of Deputy Director of Planning and Performance, removal of Claims Manager and updating job titles as appropriate throughout - Wales Audit Office updated to state Audit Wales **Annex 2:** - Inclusion of wider governance and accountability framework underpinning the Committee for reference
Strategic Development Committee	**Section 3:** - 3.4 Sub-Committees, removal of wording *'as illustrated below'* in ref. to the organigram provided **Section 4:** - 4.2 Attendees, removal of Assistant Director of Planning, Associate Director of Organisational Development and Workforce, Associate Director of Digital, Assistant Director of Communications & Engagement. Addition of Chief Digital Officer **Section 6:** - 6.1 Relationships, inclusion of Committee's role in relation to staff, patients and donors not previously captured

Terms of Reference & Operating Arrangements	Summary of Amendments
Charitable Funds Committee	**Section 5:** - 5.1 Authority, update of Executive Director of Finance job title - 5.4 Sub-Committees, update of the Charitable Funds Sub-Committee arrangements with regards to the Velindre Charity Senior Leadership Group which has been reconstituted and revised
Audit Committee	**Section 2:** - 2.3 Details of the arrangements in place for NWSSP Audit Committee included. **Section 4:** - 4.4 Acronym OD included in full i.e. Organisational Development. **Section 8:** - 8.1 Aligned to all Committee Terms of Reference and Operating Arrangements

3.2 Publication of revised Standing Orders – Schedule 4

Subject to the necessary approvals being in place as outlined above the revised Standing Orders – Schedule 3 will subsequently be uploaded to both the Trust Intranet and Internet sites.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Evidence suggests there is a correlation between governance behaviours in an organisation and the level of performance achieved at the same organisation. Therefore, ensuring good governance within the Trust can support quality care.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	
	Not Required

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

- The Trust Board is asked to **APPROVE** the amendments to the Trust Board Standing Orders – Schedule 3 as outlined in section **3** of this report, and included in ***Appendices 1-4.***

Strategic Development Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2021
Approved:	
Next Review due:	October 2022

1. INTRODUCTION

1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Strategic Development Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Strategic Development Committee "the Committee" is to provide:

- Evidence based and timely **advice** to the Board to assist it in discharging its functions and responsibilities with regard to the:

  - strategic direction
  - strategic planning and related matters
  - organisational development
  - digital services, estates and other enabler services
  - sustainable development and the implementation of strategy through the spirit and intention of the Well Being of Future Generations Act
  - investment in accordance with Value-based healthcare

- **Assurance** to the Board in relation to strategic decision-making, ensuring it is supported with a robust understanding of risks in relation to the achievement of organisational goals and strategic objectives.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board on strategic direction and organisational development, the Committee will:

- Oversee the development of the Trust's strategies and plans which set out how plans the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.

- Regularly review whether the Trust is developing a strategic approach, which provides it with the greatest opportunity to fulfil its duties under the Well-being of Future Generations (Wales) Act 2015 by means of the application of the Act's Sustainable Development Principle.

- Review the arrangements and contents of key plans to ensure alignment with the Trusts strategic goals and objectives, including the Trust's Integrated Medium Term Plan (IMTP) in accordance with above.

- Review the Trust's Capital Plan to ensure alignment with key Trust strategies, plans (IMTP) and sustainable development principles.

- Review Trust developments involving significant investment or modernisation.

- Consider the strategic implications for the Trust from the findings arising from national developments, review, audit and/or inspection, and monitor the successful implementation of any actions required resulting from these findings.

3.2 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- There is clear, consistent strategic direction, strong leadership and transparent lines of accountability.

Authority

3.2 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committees remit and ensuring patient/service user, client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- Employee (and all employees and directed to cooperate with any reasonable request made by the Committee); and

- Any other Committee, sub Committee, or group set up by the Board to assist it in the delivery of its functions.

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

- The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

- To approve policies relevant to the business of the Committee as delegated by the Board.

Access

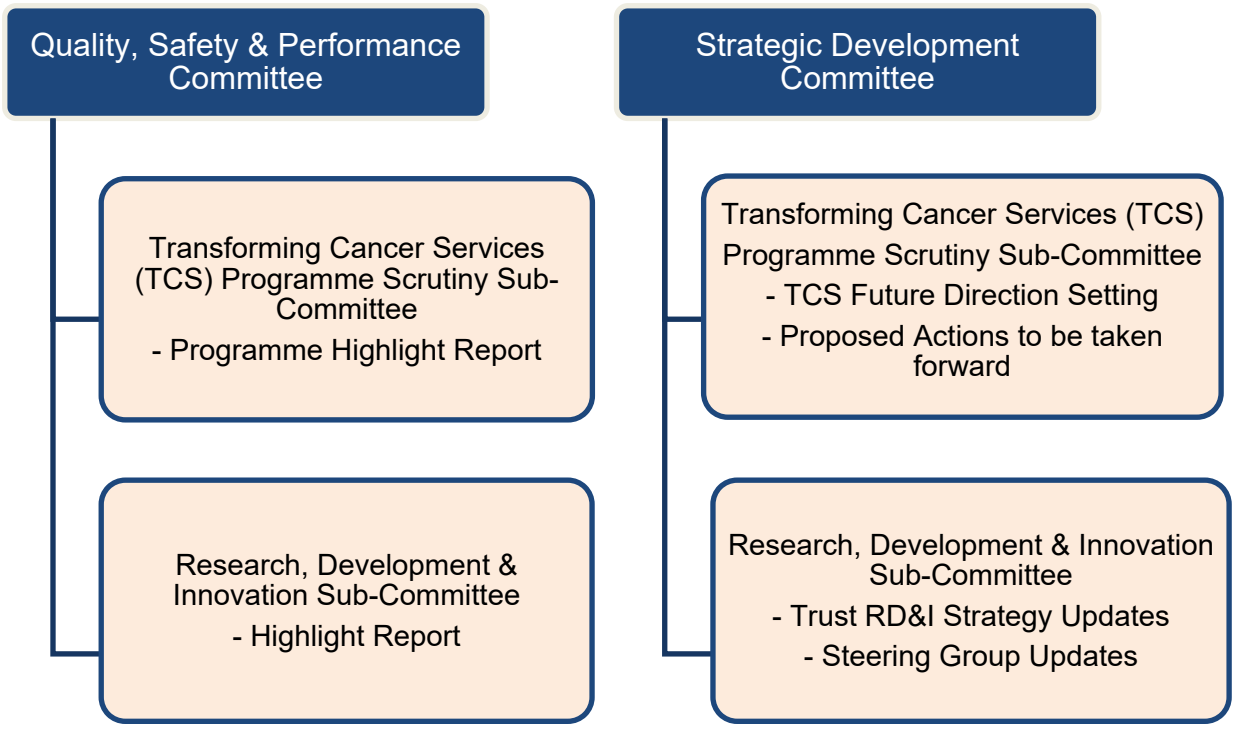
3.3 The Chair of the Strategic Development Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.4 The Committee has, with approval of the Trust Board, established the:

- Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.

The two sub-committees will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee:



Although the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they will both retain the delegated authority for decision making granted to the current committee by Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference. The Research, Development & Innovation Sub-Committee will also feed into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

4. MEMBERSHIP

Members

4.1 A minimum of two (2) members comprising:

Chair Independent member of the Board (Non-Executive Director)

One independent member of the Board (Non-Executive Directors)

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

4.2 **Attendees:**

- Chief Executive Officer
- Director of Strategic, Transformation, Estates, Planning & Digital
- Executive Director of Nursing, Allied Health Professionals and Health Scientists
- Executive Medical Director
- Chief Operating Officer
- Divisional Directors
- Director of Corporate Governance
- Executive Director of Finance
- Executive Director of Organisational Development and Workforce
- Director of Commercial and Strategic Partnerships
- Chief Digital Officer

The Committee welcomes attendance at Committee meetings by staff from within the organisation, representatives of independent and partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Audit Wales
- Trade Unions
- Community Health Council

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

4.3 **Secretariat**

As determined by the Director of Corporate Governance.

4.4 **Member Appointments**

The membership of the Committee shall be determined by the Board based on the recommendation of the Trust Chair – taking account of the balance of skills

and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

4.5 Support to Committee Members

The Director of Corporate Governance on behalf of the Committee Chair shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and

- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

5.1 Quorum

At least two independent members must be present to ensure the quorum of the Committee. If the Chair is not present an agreement as to who will chair from the Independent Members in their absence.

5.2 Frequency of Meetings

Meetings shall be held bi-monthly, consistent with the Trust's annual plan of Board Business.

5.3 Withdrawal of individuals in attendance

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its staff, patients, donors and citizens through the effective governance of the Organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees and Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business: and
- Sharing of information

In doing so, contributing to the integration of good governance across the Organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.4 The Committee shall embed the Trust's corporate objectives, priorities, and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written Highlight Reports.

- Bring to the Board's and the Accountable Officer's specific attention any significant matters under consideration by the Committee; and

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or the reputation of the Trust.

7.2 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

Cross reference with the Trust Standing Orders.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Audit Committee

Terms of Reference & Operating Arrangements

Reviewed:	December 2021
Approved:	
Next Review Due:	November 2022

1. INTRODUCTION

1.1 The Trust's standing orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Audit Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

1.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference as detailed in the NHS Wales Audit Committee Handbook June 2012.

2. PURPOSE

2.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.3 A separate Audit Committee is in operation for the NHS Wales Shared Services Partnership (NWSSP) which has its own Terms of Reference.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- The adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement, providing reasonable assurance on:

- the organisation's ability to achieve its objectives,

- compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government and others,

- the reliability, integrity, safety and security of the information collected and used by the organisation,

- the efficiency, effectiveness and economic use of resources, and

- the extent to which the organisation safeguards and protects all its assets, including its people to ensure the provision of high quality, safe healthcare for its citizens;

- The Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

- The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;

- The Schedule of Losses and Compensation;

- The planned activity and results of internal audit, external audit, clinical audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);

- The adequacy of executive and managements' response to issues identified by audit, inspection and other assurance activity via monitoring of the Trust's audit action plan;

- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and

- Any particular matter or issue upon which the Board or the Accountable Officer may seek advice from the Committee.

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by reviewing:

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances), prior to endorsement by the Board;

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the

management of principal risks and the appropriateness of the above disclosure statements;

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and

- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the NHS Counter Fraud Authority.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from other assurance providers, regulators, directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 This will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

- The comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and

- The reliability and integrity of these assurances.

3.5 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- There is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There is an effective clinical audit function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees through the effective completion of Audit Recommendations and the Committee's

review of the development and drafting of the Trust's Annual Governance;

- The work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- The work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

- The systems for financial reporting to the Board, including those of budgetary control, are effective; and that

- The results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Committee will follow and implement the Audit Committee's Annual Work plan and will be evidenced through meeting papers, formal minutes, and highlight reports to Board and annually via the Annual Governance Statement and Annual Report to the Board.

Authority

3.6 The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.

3.7 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.8 The Committee is authorised by the Board to approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.9 The Head of Internal Audit and the Auditor General for Wales and his representatives shall have unrestricted and confidential access to the Chair of the Audit Committee at any time, and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

3.10 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.11 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.12 The Committee may, subject to the approval of the Trust Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) members, comprising:

Chair	Independent member of the Board (Non-Executive Director)
	Two independent members of the Board (Non-Executive Directors)
	[one member should be a member of the Quality, Safety & Performance Committee]
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.
	The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

4.2 In attendance:

Chief Executive (*who should attend once a year as a minimum to discuss with the Committee the process for assurance that supports the Annual Governance Statement.)*
Executive Director of Finance
Director of Corporate Governance
Chief Operating Officer
Head of Internal Audit
Local Counter Fraud Specialist
Representative of the Auditor General for Wales

By invitation — The Committee Chair may invite:

- the Chair of the organisation
- any other Trust officials; and/or
- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.1 Secretary — As determined by the Director of Corporate Governance

Member Appointments

4.2 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.3 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

4.4 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the Committee.

Frequency of Meetings

5.2 Meetings shall be held no less than 4 times per year, and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business. The External Auditor or Head of Internal Audit may request a meeting with the Chair if they consider that one is necessary.

Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, the Board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board by taking into account:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and sub Committees to meet its responsibilities for advising the Board on the adequacy of the Trust's overall system of assurance by receipt of their annual work plans.

6.5 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;

- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.

7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

Cross reference with the Trust Standing Orders.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In

these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee, after first consulting with two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Charitable Funds Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2021
Approved:	
Next Review due:	October 2022

1. INTRODUCTION

1.1 The Trust's standing orders provide that "*The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In accordance with standing orders (and the Trust's scheme of delegation), the Board shall nominate annually a Committee to be known as the **Charitable Funds Committee** "the Committee". The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. CONSTITUTION

2.1 The Velindre University NHS Trust Board was appointed as corporate trustee of the charitable funds by virtue of the Velindre National Health Service Trust (Establishment) Order No. 2838 that came into existence on 1st December 1993, and that its Board serves as its agent in the administration of the charitable funds held by the Trust.

2.2 The purpose of the Committee" is to make and monitor arrangements for the control and management of the Trust's Charitable Funds.

3. SCOPE AND DUTIES

3.1 Within the budget, priorities and spending criteria determined by the Trust as trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) to apply the Charitable Funds in accordance with their respective governing documents.

3.2 To ensure that the Trust policies and procedures for Charitable Funds investments are followed. To make decisions involving the sound investment of Charitable Funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with:

- Trustee Act 2000
- The terms outlined in the Velindre NHS Trust Charity's Governing Documents

3.3 At least twice a year, receive highlight reports from the Executive Director of Finance in respect of investment decisions, performance and action taken through delegated powers upon the advice of the Trust's Investment adviser.

3.4 To oversee and monitor the functions performed by the Executive Director of Finance as defined in Standing Financial Instructions.

3.5 To respond to, and monitor the level of donations and legacies received, including the progress of any Charitable Appeal Funds where these are in place and considered to be material.

3.6 To monitor and review the Trust's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.

3.7 To ensure that funds are being utilised appropriately in accordance with both the instructions and wishes of the donor, and to ensure that fund balances are maintained in accordance with the Reserves Policy.

4. DELEGATED POWERS AND DUTIES OF THE EXECUTIVE DIRECTOR OF FINANCE

4.1 The Executive Director of Finance has prime responsibility for the Trust's Charitable Funds as defined in the Trust's Standing Financial Instructions. The specific powers, duties and responsibilities delegated to the Executive Director of Finance are:

- Administration of all existing Charitable Funds.
- To identify any new charity that may be created (of which the Trust would also be Trustee). Ensuring that all legal requirements are followed in the creation of any new charity in order to formalise the governing arrangements.
- Provide guidelines with response to donations, legacies and bequests, fundraising and trading income.
- Responsibility for the management of investment of funds held on trust.
- Ensure appropriate banking services are available to the Trust.
- Prepare reports to the Trust Board including the Annual Accounts and Annual Report.

5. AUTHORITY

5.1 The Committee is empowered with the responsibility for:

- Overseeing the day to day management of the investments of the Charitable Funds in accordance with the investment strategy set down from time to time by the Trustees and the requirements of the Trust's Standing Financial Instructions.
- The appointment of an Investment Manager (where appropriate) to advise it on investment matters. Delegating, where applicable, the day-to-day management of some or all of the investments to that Investment

Manager. In exercising this power the Committee must ensure that:

a) The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it.
b) There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently.
c) The performance of the person or persons exercising the delegated power is regularly reviewed.
d) Where an investment manager is appointed, that the person is regulated under the Financial Services Act 2012.
e) Acquisitions or disposal of a material nature must always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance.

- Ensuring that the banking arrangements for the Charitable Funds are kept entirely distinct from the Trust's NHS funds.

- Ensuring that arrangements are in place to maintain current account balances at minimum operational levels consistent with meeting expenditure obligations, the balance of funds being invested in interest bearing deposit accounts.

- The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.

- The operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the Trust Board for applying accrued income to individual funds in line with charity law and Charity Commission guidance.

- Obtaining appropriate professional advice to support its investment activities.

- Regularly reviewing investments to see if other opportunities or investment services offer a better return.

5.2 The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust relevant to the Committee's remit. It can seek any relevant information it requires from any employee and all employees are directed to co-operate with any reasonable request made by the Committee;

- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise

if it considers this necessary, subject to the Board's budgetary and other requirements; and

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

5.3 Approve policies relevant to the business of the Committee as delegated by the Board.

5.4 **Sub Committees**

As part of its function, the Charitable Funds Committee has determined to establish a Sub Committee, the *'Charitable Funds Investment Performance Review Sub Committee'*, to specifically monitor the performance of the Investment portfolio on its behalf whilst recognising that the Trust Board as Corporate Trustee is ultimately accountable.

The Charitable Funds Committee is also supported by the Velindre Charity Senior Leadership Group, whose purpose on behalf of the Board of Trustees is to support the development of the strategic direction, take forward strategic delivery and operational management of all Charitable Funds held within the Trust.

In addition, the Trust Research, Development & Innovation Sub-Committee has been established to act as the 'front door' for all RD&I business at Board level. The RD&I Sub Committee will feed into the Charitable Funds Committee for alignment with strategy and funding.

6. MEMBERSHIP

Members

6.1 A minimum of four members, comprising:

- Chair, Independent member of the Board (Non-Executive Director)
  Independent Member of the Board (Non-Executive Director)The Trust's Chief Executive and Executive Director of Finance (one of which at any one meeting may be represented by a Nominated Representative in their absence)

Attendees

6.2 In attendance The Committee may require the attendance for advice, support and information routinely at meetings from:

- Charity Director
- Chief Operating Officer
- Director Velindre Cancer Centre (or their deputy)
- Director of Welsh Blood Service (or their deputy)
- Investment Manager/Advisor
- Patient Representative
- Charitable Funds Accountant
- Deputy Director of Finance
- Head of Fundraising
- Head of Corporate Governance (Charity Governance Lead)
- Head of Communications

By invitation, The Committee Chair may invite:

- any other Trust officials; and/or
- any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

6.3 Secretary As determined by the Director of Corporate Governance

Member Appointments

6.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

6.5 Applicable to Independent Members only. Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

6.6 In order to demonstrate that there is a visible independence in the consideration of decisions and management of charitable funds from the Trust's core functions, the Board should consider extending invitations to the Charitable Funds Committee to individuals outside of the Board. One option might be to seek representation from the Patient Liaison Group.

Support to Committee Members

6.7 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure and co-ordinate the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Organisational Development & Workforce.

7. COMMITTEE MEETINGS

Quorum

7.1 At least two members must be present to ensure the quorum of the Committee. Of the two, one must be an Independent Member and one must be the Executive Director of Finance or Nominated Representative.

Frequency of meetings

7.2 Meetings shall be held every three months and otherwise as the Committee Chairs deems necessary - consistent with the Trust's annual plan of Board Business.

Withdrawal of individuals in attendance

7.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1 The Committee will only consider Research and/or Innovation proposals seeking charitable funding that have been scrutinised and endorsed by the Research, Development & Innovation Sub-Committee. This will ensure that the quality and safety of RD&I activity has been considered and is consistent with the RD&I Strategy.

8.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

8.3 The Committee, through its Chair and members, shall work closely with the Board and, [*where appropriate, its Committees and Groups]*, through the:

- joint planning and co-ordination of Board and Committee business; and
- appropriate sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall agree arrangements with the Trust's Chair to report to the Board in their capacity as Trustees. This may include, where appropriate, a separate meeting with the Board.

9.2 The Committee Chair shall report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year.

9.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

Cross reference with the Trust Standing Orders.

11. REVIEW

11.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

12. CHAIR'S ACTION ON URGENT MATTERS

12.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

12.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2021
Approved:	
Next Review due:	October 2022

1. INTRODUCTION

1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Quality, Safety and Performance Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Quality, Safety and Performance Committee "the Committee" is to provide:

- Evidence based, timely **advice** and **assurance** to the Board, to assist it in discharging its functions and meeting its responsibilities through its arrangements and core outcomes with regard to:
  - quality, safety, planning and performance of healthcare;
  - safeguarding and public protection;
  - patient, donor and staff experience;
  - all aspects of workforce;
  - digital delivery and information governance;
  - relevant statutory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Well-being of Future Generations (Wales) Act 2015;
  - Health and Care Standards (2015);
  - financial performance;
  - regulatory compliance; and,
  - organisational and clinical risk.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of **advice** and **assurance** to the Board use where possible a triangulated approach to:

- Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities;

- Ensure the Trust has in place a robust Quality Management System and is working towards meeting the requirements outlined in the Wales Quality Framework: Learning & Improving (2021);

- Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board;

- Consider the implications for the Trust's quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arrangements from review/investigation reports and actions arising from the work of external regulators;

- Monitor progress against the Trust's Integrated Medium Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board;

- Align service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.

- Monitor the Trust's sustainability activities and responsibilities;

- Monitor progress against cost improvement programmes;

- Monitor and review performance against the Trust's Assurance Framework.

- Ensure areas of significant patient / donor / service / performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation;

- Monitor outcomes/outputs from patient / donor / service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery;

- Assess implications of any relevant existing, new or amended statutory and regulatory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and oversee the Trust's implementation;

- Ensure the Trust Policies, Procedures and Strategies are consistent with internal and external legislative and regulatory requirements and are implemented effectively;

- Ensure the Trust, at all levels (divisional/team) has a citizen centred approach, putting patients, patient / donor experience, safety and safeguarding above all other considerations;

- Ensure that care and services are planned and delivered in line with relevant national / statutory / regulatory and best practice standards;

- Ensure the Trust has the right systems and processes in place to deliver patient /donor focused, efficient, effective, timely and safe services;

- Ensure the workforce is appropriately selected, trained, supported and responsive to the needs of the Trust, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;

- Ensure there is effective collaboration with partner organisations and other stakeholders

in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- Ensure the integrity of data and information is protected, valid, accurate, complete and timely data and information is available to support decision making across the Trust;

- Ensure there is an ethos of learning and continual quality improvement and a safety culture that supports safe high quality care ;

- Ensure there is good team working, collaboration and partnership working to provide the best possible outcomes for our citizens;

- Ensure risks are actively identified and robustly managed at all levels of the Trust;

- Ensure the Health and Care Standards (2015) are used to monitor and improve standards across the Trust;

- Ensure all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality, safety and performance of care provided, and in particular that:

  - sources of internal assurance are reliable
  - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
  - lessons are learned from concerns, incidents, complaints and claims.

- Ensure there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board; and,

- Advise the Board about key indicators of quality, safety and performance, which will be reflected in the Trust's performance framework, against which performance will be regularly assessed and reported on through Annual Reports.

Authority

3.2 The Committee is authorised by the Board to investigate or commission investigation of any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, ensuring patient, and donor and staff confidentiality, as appropriate. The Committee may seek relevant information from:

- Employees (and all employees are directed to co-operate with any reasonable request made by the Committee), and any other Committee, Sub-Committee or Group set up by the Board to assist it in the delivery of its functions.

- Obtain legal / other providers of independent professional advice, and to secure the attendance of individuals external to the Trust who have relevant experience and expertise if necessary, and in accordance with the Board's procurement, budgetary and other requirements.

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Trust at any meeting of the Committee.

3.3 Approve policies relevant to the business of the Committee as delegated by the Board.

Access

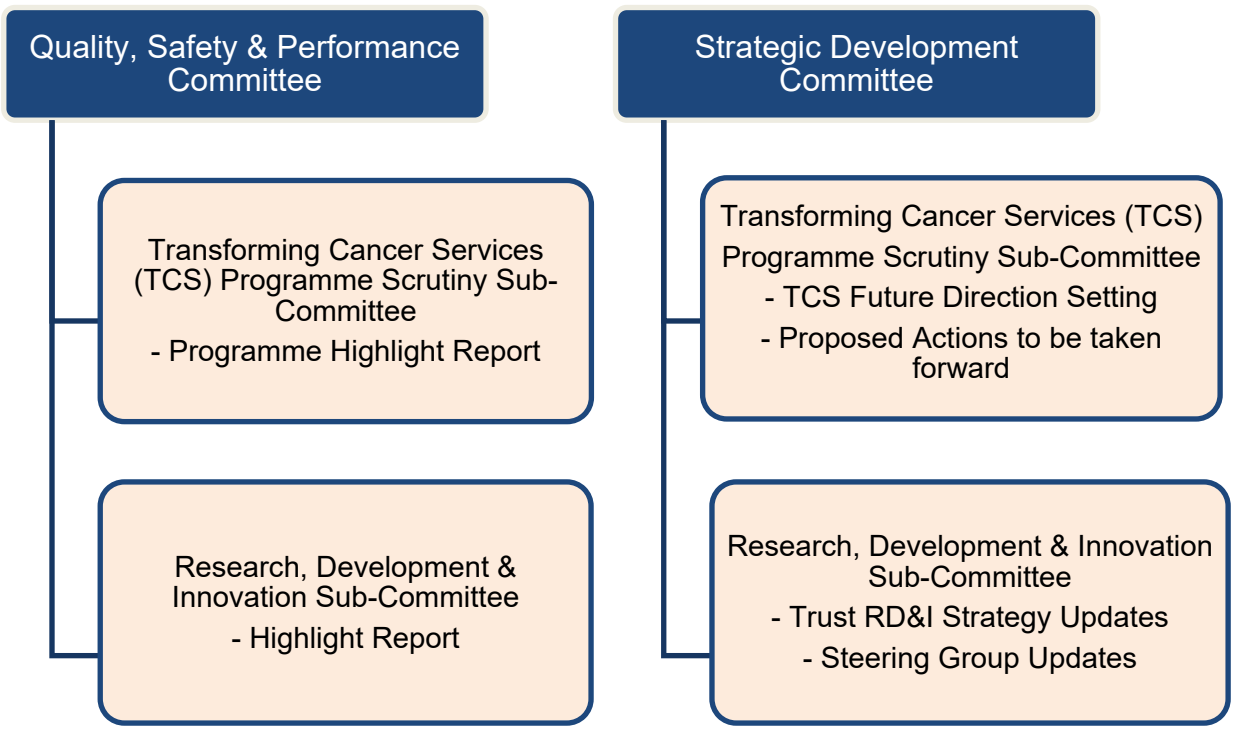
3.4 The Chair of the Quality, Safety & Performance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.5 The Committee has, with approval of the Trust Board, established the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and the Research, Development & Innovation Sub-Committee.

Note: an overarching summary of the Trust's Governance & Accountability Framework is provided at ***Annex 1***. In addition, the wider governance and accountability reporting arrangements in place at a local divisional level that feed upwards into the Quality, Safety & Performance Committee structure are also summarised at ***Annex 2***.

The two sub-committees have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as illustrated below:



Although the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they both retain the delegated authority for decision making granted by the Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference. The Research, Development & Innovation Sub-Committee also feeds into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

4. MEMBERSHIP

Members

4.1 A minimum of two (2) members, comprising:

Chair	Independent member of the Board (Non-Executive Director) One independent member of the Board (Non-Executive Directors) The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

4.2 **Attendees:**

- Chief Executive Officer
- Executive Director of Nursing, Allied Health Professionals and Health Science (Committee Lead Executive Officer)
- Executive Medical Director *(also Caldicott Guardian)*
- Chief Operating Officer
- WBS & VCC Divisional Directors
- Directors of Hosted Organisations or representatives
- Director of Corporate Governance & Chief of Staff
- Executive Director of Finance
- Executive Director of Organisational Development & Workforce
- Director of Strategic Transformation, Planning & Digital
- Deputy Director of Planning & Performance
- Deputy Director of Nursing, Quality & Patient Experience
- Chief Digital Officer (*also cyber/data outtages/performance)*
- Quality & Safety Manager
- Head of Corporate Governance

4.3 **By invitation**

The Committee Chair may extend invitations to individuals from within or outside the organisation, taking account of the matters under consideration at each meeting. The Committee welcomes attendance at Committee meetings by staff from within the Organisation, representatives of independent and partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Audit Wales
- Trade Unions
- Community Health Council

Secretariat

4.4 Secretary - as determined by the Director of Corporate Governance & Chief of Staff

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

4.7 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Organisational Development & Workforce.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two independent members must be present to ensure the quorum of the Committee. If the Chair is not present an agreement as to who will chair from the independent members in their absence.

Frequency of Meetings

5.2 Meetings shall be held no less than bi-monthly and otherwise, as the Chair of the Committee deems necessary.

Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality, safety and performance of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including Joint (Sub) Committees and Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and

assurance framework.

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.5 The Committee shall embed the Trust's corporate objectives, priorities and requirements, e.g. equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Provide a formal report to the Board of the Committee's activities. This includes updates on activity and triangulated assurance outcomes through the submission of written Committee Highlight Reports and other relevant written reports, as well as the presentation of an annual Quality, Safety & Performance Committee report;

- Bring to the Board's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient / donor care and affect the operation and/or reputation of the Trust.

7.2 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

Cross reference with the Trust Standing Orders.

9. REVIEW

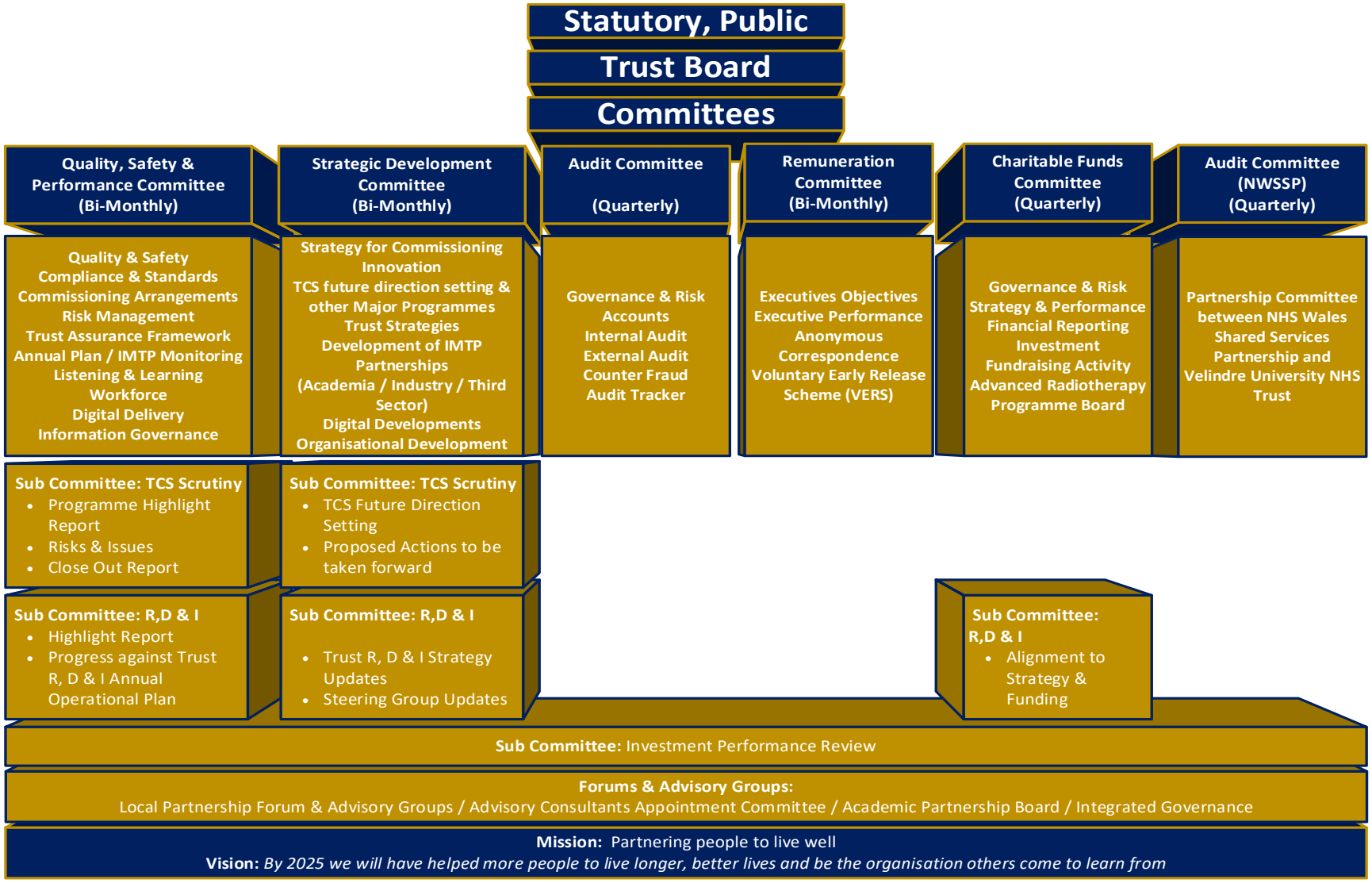
9.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

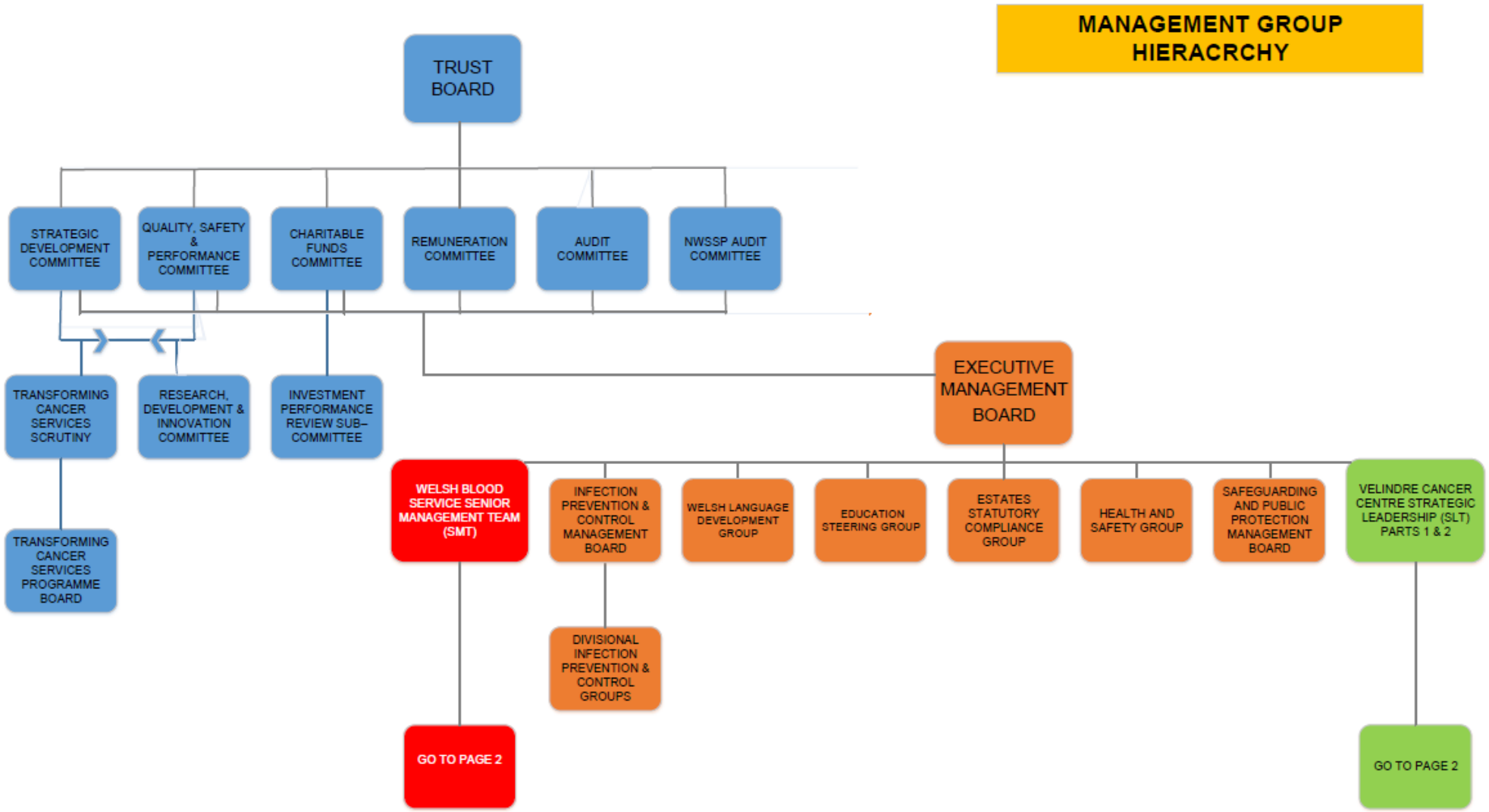
10.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

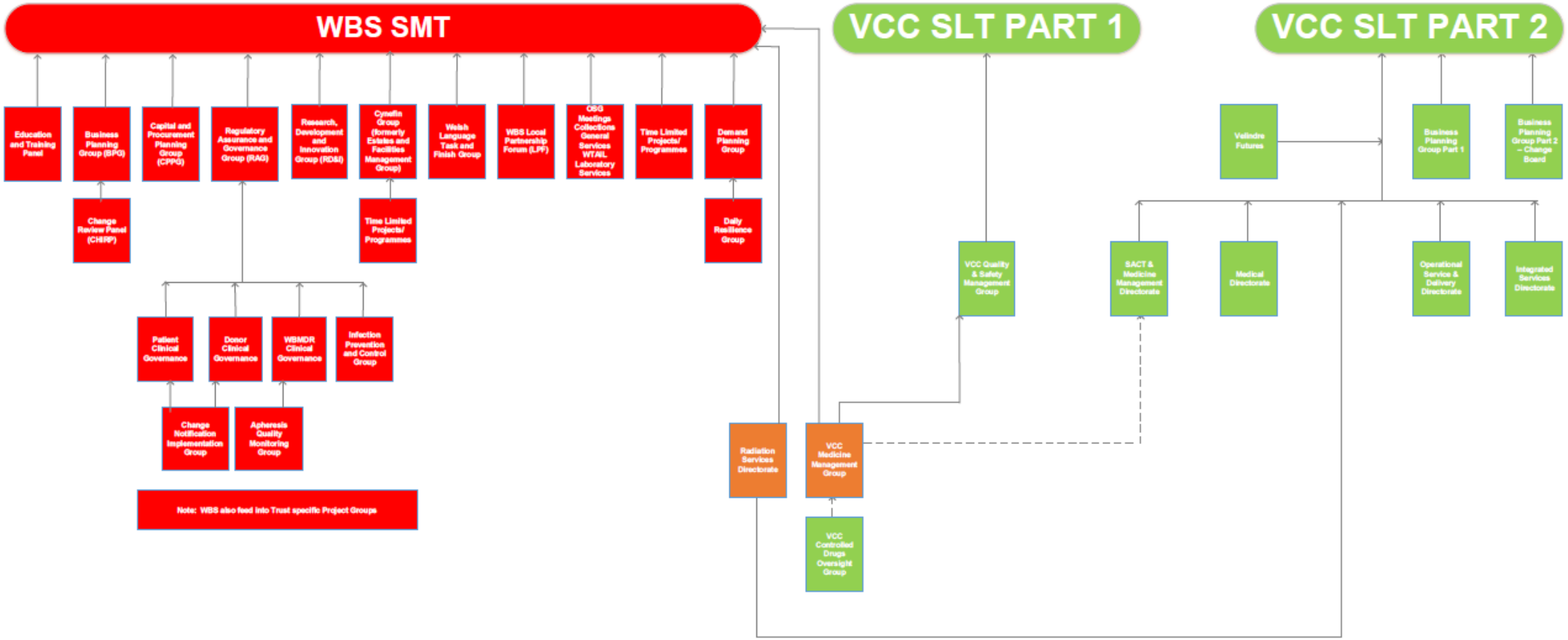
10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK



ANNEX 2 – WIDER GOVERNANCE & ACCOUNTABILITY FRAMEWORK




WBS SMT
VCC SLT PART 1
VCC SLT PART 2
Education and Training Panel
Business Planning Group (BPG)
Capital and Procurement Planning Group (CPPG)
Regulatory Assurance and Governance Group (RAG)
Research, Development and Innovation Group (RD&I)
Cynefin Group (formerly Estates and Facilities Management Group)
Welsh Language Task and Finish Group
WBS Local Partnership Forum (LPF)
C&G Meetings Collections General Services WTAIL Laboratory Services
Time Limited Projects/ Programmes
Demand Planning Group
Change Review Panel (CHRP)
Time Limited Projects/ Programmes
Daily Resilience Group
Patient Clinical Governance
Donor Clinical Governance
WBMDR Clinical Governance
Infection Prevention and Control Group
Change Notification Implementation Group
Apheresis Quality Monitoring Group
Note: WBS also feed into Trust specific Project Groups
VCC Quality & Safety Management Group
Radiation Services Directorate
VCC Medicine Management Group
VCC Controlled Drugs Oversight Group
Velindre Futures
Business Planning Group Part 1
Business Planning Group Part 2 – Change Board
SACT & Medicine Management Directorate
Medical Directorate
Operational Service & Delivery Directorate
Integrated Services Directorate

TRUST BOARD

REMUNERATION COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	27th January 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Donna Mead, Chair
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Director of Organisational Development and Workforce

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper had been prepared to provide the Trust Board with details of the key issues considered by the Remuneration Committee on 13.12.2021.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nothing of note to report
ADVISE	**Authorisation of Redundancy Payment – Following Fixed Term Contract Completion** The Remuneration Committee approved a redundancy payment following completion of a fixed term contract.
ASSURE	Nothing of note to report.
INFORM	**Recruitment of Members of the Executive Team** The Committee noted the appointment of: • Chief Operating Officer • Executive Director of Finance
APPENDICES	**NOT APPLICABLE**

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE LOCAL PARTNERSHIP FORUM

DATE OF MEETING	27.01.2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Carol Meredith, Business Support Officer
PRESENTED BY	Sarah Morley, Executive Director of OD & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of OD & Workforce
REPORT PURPOSE	FOR NOTING

ACRONYMS	
LPF	Local Partnership Forum
SLT	Senior Leadership Team
VCC	Velindre Cancer Centre
OCP	Organisational Change Programme
WBS	Welsh Blood Service
RCN	Royal Collage of Nursing

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Local Partnership Forum held on 1st December 2021.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nothing to escalate
ADVISE	
ASSURE	
INFORM	**Local Partnership Forum received an update on The People Strategy** • An update was provided of the development and themes contained within the People Strategy which has been developed to align with other enabling strategies for the organisation which all sit under the New Trust Strategy. **Velindre Cancer Centre Wellbeing Event** • It was reported that a successful Wellbeing event was organised by the Workforce team and other colleagues. Around 50 VCC staff attended in the Maggie Centre on the 22nd November. • A discussion took place around COVID sick pay and the payment for those staff with Long Covid **Trade Union Update** • The Welsh Government has completed the first stage of the consultation on the Social Partnership and Public Procurement Bill. The bill seeks to use legislative leavers to meet the well-being and Fair Work goals outlined in the Well-Being of Future Generations Act. **Feedback from IPA Workshops** • The Forum discussed the two workshops which were held in October 2021 with Trades Union representatives and Trust senior managers. The purpose of the workshops was to refresh the partnership working ethos in the organisation. • The meeting was advised that the workshops were well attended with the content being appreciated by all who attended.

	• Actions have been taken from the workshops which will progressed in partnership. **Trade Union Joint Chair of Local Partnership Forum** **Management of Violence and Aggression Update** • NHS Wales issued an update in April 2021 to the obligatory response document, which is the national document outlining the need for Health Boards and Trusts to respond to issues of violence and aggression within their Organisations. • The Forum received an update on the Trust actions in this area from the Trust Health and Safety Manager recognising that across the organisation, our profile in terms of violence and aggression is quite low compared to other NHS Wales organisations **Agile Working** • The purpose of group is to look at how we work currently and how we will work moving forward, linking into the operational group linked into wider Agile Working Board.
APPENDICES	

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	27th January 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	
OBC	Outline Business Case
FBC	Full Business Case
TCS	Transforming Cancer Services
WG	Welsh Government
IRS	Integrated Radiotherapy Solution
IM	Independent Member

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Transforming Cancer Service (TCS) Programme Scrutiny Sub-Committee at its public meeting on 25th October 2021.

1.2 This is not considered a full update on the Programme but a high level record of the matters of business conducted by the TCS Programme Scrutiny Sub-Committee.

1.3 Key highlights from the meeting are reported in section 2.

1.3 The Trust Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Trust Board.
ADVISE	**Finance Report** The finance report for October 2021 was received. A small revenue overspend to October 2021 was noted, with a current year-end forecast of £0.017m. This will be managed within the overall budgets. It was highlighted there is a projected year-end capital overspend of £0.124m for the Integrated Radiotherapy Solution (IRS) Project. This overspend will be managed within the wider Transforming Cancer Service Programme. The sub-committee **noted** the finance report. **TCS Programme Risk Register** The TCS Programme Risk Register report was presented. The latest risk positions for the TCS programme and projects were reviewed and discussed. Risks which relate to programme resources will be updated in the November Scrutiny Sub-Committee, and they will also be included in the financial strategy which will be going to the next Trust Board meeting. The sub-committee **noted** the finance report.

	Project Delivery Updates were received in the following papers which were **noted**: - Charity Interface - Children's & Young Persons Engagement (Minecraft) - Collaborative Centre – Update - Wellbeing & future generations Act (WBFGA) – new Velindre Cancer Centre Status report
ASSURE	**Project 4 – Radiotherapy Satellite Centre** **FBC Timeline Update** A verbal update was given on the FBC timeline. The sub-committee noted the verbal update. **Nuffield Trust Recommendations: Progress** An update on progress with the Nuffield Trust Recommendation was received. The Sub-Committee **Noted** the Paper. **Communications & Engagements** An update was given on communication and engagements. The Sub-Committee **Noted** the Paper.
INFORM	There were no items identified to inform the Trust Board
APPENDICES	N/A

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE TRANSFORMING CANCER SERVICES SCRUTINY SUB-COMMITTEE

DATE OF MEETING	27th January 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	
OBC	Outline Business Case
FBC	Full Business Case
TCS	Transforming Cancer Services
WG	Welsh Government
IRS	Integrated Radiotherapy Solution
IM	Independent Member

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Transforming Cancer Service (TCS) Programme Scrutiny Sub-Committee at its public meeting on 22nd November 2021.

1.2 This is not considered a full update on the Programme but a high-level record of the matters of business conducted by the TCS Programme Scrutiny Sub-Committee.

1.3 Key highlights from the meeting are reported in section 2.

1.3 The Trust Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Trust Board.
ADVISE	**Finance Report** A summary was provided for the TCS Finance report as at October 2021. Capital: £1.5M year to date spend, with a year-end forecast spend of £4.3M | Revenue: £400K year to date spend, with a year-end forecast spend forecast of £600K. Projected year-end out-turn currently is £113k overspend on Capital and £17k overspend on Revenue. Within this, it was highlighted there are two financial risks which needed to be brought to the attention of the TCS Programme Scrutiny Sub-Committees attention which are: 1. Project 3a - Integrated Radiotherapy Solution (IRS) Project: due to the delay in procurement this has resulted in a deficit of £116K (Capital). 2. Project 6 - Service Change Project: a £17k Revenue overspend against this Project delivery is the main risk to the outturn position for the programme. The sub-committee **noted** the finance report. **TCS Programme Risk Register**

	The TCS Programme Risk Register report was presented. The latest risk positions for the TCS programme and projects were reviewed and discussed. The sub-committee **noted** the Risk Register.
ASSURE	**Programme Resource Update** The Programme Resource paper was presented to the Sub-Committee. Previously the TCS Programme Scrutiny Sub-Committee members have raised the issue of programme resourcing on a number of occasions as there are a number of risks which have remained with a high-risk rating for an extended period. It was confirmed significant progress has already been made. Further work is required to determine any additional capacity required in Velindre Futures as it takes responsibility for Clinical Transformation. The Sub-Committee **Noted** the Programme Resource Paper. **Communications & Engagements** An update was given on communication and engagements. The Sub-Committee **Noted** the Paper.
INFORM	There were no items identified to inform the Trust Board.
APPENDICES	N/A

TRUST BOARD

Communications and Engagement Update

DATE OF MEETING	27th January 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	FRANCESCA CARPANINI, SENIOR COMMUNICATIONS AND ENGAGEMENT MANAGER
PRESENTED BY	NON GWILYM, ASSISTANT DIRECTOR COMMUNICATIONS AND ENGAGEMENT
EXECUTIVE SPONSOR APPROVED	LAUREN FEAR, DIRECTOR CORPORATE GOVERNANCE & CHIEF OF STAFF

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
TCS Programme Board	17 January	Noted
TSC Programme Scrutiny Sub-Committee	19 January	Noted#

ACRONYMS	
nVCC	New Velindre Cancer Centre

TCS	Transforming Cancer Services
VCC	Velindre Cancer Centre

1. SITUATION

2. BACKGROUND

This paper provides the Board(s) with an update on communications and engagement during the course of December 2021.

The Programme Board approved the Transforming Cancer Services (TCS) Programme Communications and Engagement strategy in December 2019. The strategy emphasises the importance of good one-to-one stakeholder engagement, building positive relationships and informing our patients, staff and communities of interest.

3. ASSESSMENT

Over the reporting period we focused our efforts on:

- **Strategic counsel and preparing communications and engagement support ahead of planned next stages of work on site**
    1. Producing communications action plan and drafting subsequent content for internal and external stakeholders
    2. Coordinating briefing meetings with identified stakeholders ahead of works beginning; this includes MS MP, ward Councillors, Hollybush Estate Residents Association and liaison with other key community groups.
- **Managing media enquiries and related social media commentary** as part of the ground investigation works. Coverage outlined below
    - https://www.walesonline.co.uk/news/wales-news/velindre-cancer-centre-protesters-contractors-22391940
- **Responding to correspondence from a wide range of stakeholders.** There continues to be a significant amount of incoming correspondence over the past

month in response to the preparatory works that took place on site. The key recurring themes are:
    - enabling works, contractors and the required permissions
    - air quality monitoring
    - challenges in relation to the clinical model and patient safety
    - impact on trust in the Velindre brand and its wider reputation within the community
    - flooding risk to area
    - decision on the Hollybush emergency bridge and the potential alternative
- **Political stakeholder meetings** – in addition to the regular meetings with the local constituency MS and MP, we continue to build relationships with the existing ward Councillors and liaison with candidates standing for election in May 2022.
- **Media relations** ahead of publication regarding future of current VCC site, Whitchurch Hospital and the Whitchurch Master Plan
    - https://nation.cymru/news/uncertain-future-for-the-current-velindre-site-once-the-new-cancer-hospital-is-built/
    - https://www.walesonline.co.uk/news/local-news/around-200-homes-could-built-22427896
- **Development of 'myth busters'** to mitigate the ongoing misinformation regarding key aspects of the project, which will include ecological, clinical and management information
- **Designs finalised for engagement hub space with VCC** – two hubs will be installed by end of January 2022 – that will cover overarching project engagement opportunities and one that will focus on green ambitions, as well as community benefits
- **Implementing a plan to promote clinical messaging**, which will support the 'myth busters' but also provide a wider context for media and additional digital content for the project and Trust as a whole
- **Supporting the development of a wider value added package –** suggested name Velindre Together – for socialising with staff and stakeholders in early 2022.

For the next month, our priorities will be as follows:

- Second phase site clearance (tree clearance) communications and engagement activity to ensure project team and contractors are appropriately supported;
- Supporting the development of the injunction case;
- Implementing the feedback plan through the engagement hubs at VCC that allows us to track and score staff and patient sentiment, understanding and ideas;
- Update and publish new FAQs onto Trust website;
- Recruitment of project Engagement Manager and Communications Manager following the resignation of the Senior Communications Manager on 8 December 2021;
- Continue to socialise the Value Add Engagement Programme to garner support and develop appropriate plans for each aspect of the programme to deliver in 2022;
- Publish next issue of Velindre Matters digital newsletter;
- Drafting and approving Velindre Matters community newspaper content for distribution early February 2022;
- Support meetings with MS and MP
- Promote new content on the Velindre Matters social channels;
- Continue to monitor opposition social media channels and advise accordingly;
- Supporting the nVCC research and development working group, alongside its Trust counterpart;
- Supporting the patient engagement framework and related activities.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

5.1 The Trust Board are recommended to **NOTE** the paper.

TRUST BOARD

AUDIT COMMITEE HIGHLIGHT REPORT

DATE OF MEETING	11/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alison Hedges, Business Support Officer
PRESENTED BY	Martin Veale, Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
~	~

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Audit Committee at its meeting held on the 11 January 2022.

Key highlights from the meeting are reported in Section 2.

The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the Audit Committee held on the 11 January 2022:

ALERT / ESCALATE	There were no items for alerting or escalating to the Trust Board.
ADVISE	**TRUST MODEL STANDING ORDERS & STANDING FINANCIAL INSTRUCTIONS** The Audit Committee **ENDORSED** FOR **BOARD APPROVAL**: • Amendments to Velindre University NHS Trust Model Standing Orders and Standing Financial Instructions – Schedule 3 **EXTERNAL AUDIT** **STRUCTURED ASSESSMENT 2021 (PHASE 2) CORPORATE GOVERNANCE & FINANCIAL MANAGEMENT ARRANGEMENTS** The report sets out the findings from Phase 2 of the Auditor General's structured assessment work at the Trust. The report set out two recommendations both of which have been accepted by management. It was highlighted that management actions have been implemented to fully address the first of the two recommendations provided. The Audit Committee **REVIEWED** and **NOTED** the report.
ASSURE	**TRUST RISK REGISTER** The Audit Committee **DISCUSSED** & **REVIEWED** the risk report with information on the status of organisational risks recorded in the Trust Risk Register, as part of the ongoing management and mitigation of risks. The report focussed on risks assessed at level 20, 16, 15, and 12, and risks with impact of five, in accordance with the agreed Trust risk appetite levels. Further information will be included for **ASSURANCE** to the May meeting of the Audit Committee to provide: • Holistic view of which risks are overseen by what Board Committee and the management arrangements in place • Hierarchy of risks i.e., where each individual risk sits in relation to higher level / strategic risks The Audit Committee **NOTED**: • A project plan is in place and actions undertaken to expedite progress in establishing a consolidated risk process for the Trust. • Further work in January 2022 to update the organisational risk profile in view of the changing COVID risk profile will be received by the Quality, Safety & Performance Committee and Trust Board. **TRUST ASSURANCE FRAMEWORK** The Audit Committee **DISCUSSED** & **REVIEWED** the further development of the Trust Assurance Framework (TAF), together with the ongoing work to support its continued development, articulation and operationalisation within the Velindre University NHS Trust. The Audit Committee requested further visibility of the Trust strategic objectives and the risks that contribute against strategic objectives, supported by an overall

	hierarchy of risks as outlined above in the development of the risk management framework. **LOSSES AND SPECIAL PAYMENTS REPORT** The Audit Committee **NOTED** approximately £90,000 aged debt has been written off by the Trust as at the end December 2021; the vast majority of which (£83,000) were aged private patient debts. The Committee **NOTED** the management actions underway and arrangements in place for additional **ASSURANCE**. **AUDIT WALES POSITION STATEMENT** The Committee received an overview on the current status of Audit Wales' work, including the ongoing Audit of the Chartable Funds and received **ASSURANCE** that this is expected to be completed in readiness for submission to the Charity Commission by 31 January 2022. **UPDATE ON THE AUDIT WALES APPROACH TO THE AUDIT IF INVENTORIES FOR 2021-22** Auditing standards ISA501 require Audit Wales to attend physical stock counts where inventory balance is material. Audit Wales plan to attend stock counts at several store locations and undertake audit procedures, subject to risk assessments for both NWSSP & Velindre Trust being completed and shared with WAO and WAO own risk assessments allowing its staff to attend the stores. Any changes to WG Covid policy may also impact on this assessment, however it was agreed by WAO that their aim is to undertake physical site visits The audit work and opinion for 2021-22 relates to the inventory at 31st March '22, not the comparative year figures. The audit will need to provide assurance over the opening stock through review of in-year transactions and the cost of stock in the year.
INFORM	**COUNTER FRAUD ANNUAL REPORT 2020/21** Resources have increased, role of Manager out for advert, with closing date end January 2022, and by the start of the new financial year should be up to full capacity. Well on track to fulfilling commitment for allocated days for Velindre Trust. **COUNTER FRAUD PROGRESS REPORT FOR THE PERIOD 1st OCTOBER 2021 TO 30th DECEMBER 2021** Highlighted and noted below to the Audit Committee: • Two open investigations linked directly to Velindre Trust. One of which potential frauds have been identified and need more witness statements. Other recent and ongoing in process of gathering witness statements. • Completed 90 days of allocated 110. • Resources have increased. Previously one person in admin, replaced role with an accredited Investigator, appointed and will do NHS Fraud Training. Will then have 3 investigators and a manager. • Need to include sorts of values involved in the reports going forward.

AUDIT COMMITTEE ANNUAL REPORT
The Audit Committee **APPROVED** the Committee's Annual Report, and this is to be **NOTED** by the January 2022 Trust Board.

RECEIPT OF FINANCE TECHNICAL UPDATES
Finance Technical update was provided on IFRS 16 Leases. Information included in the report is essentially the same as reported over the last 2 years from when the IFRS came into force but has been deferred implementation in NHS. IFRS16 will impact on our financial statements from 2022-2023 onward. The Trust is working with colleagues across NHS Wales and Welsh Government to make sure we are ready for implementation of the standard.

INTERNAL AUDIT REPORTS:

Title	**Assurance Rating**	**Audit Committee Outcome of Recommendations**
2021/22 Progress Update Report		Formally **AGREED** the changes to the 2021-22 audit plan to include an advisory audit on the Trust new ways of working and an audit on DBS checks to replace two audits deferred / removed
Board Committee Effectiveness	Reasonable assurance	**NOTED** the report
Trust Assurance Framework	Reasonable assurance	**NOTED** the report
Use of Technology – Fit for the Future	Advisory review	**NOTED** the report

OTHER BUSINESS:
The Committee also received written or verbal reports under the following agenda items:
Procurement Compliance Report
Audit Action Tracker – Overdue and Completed Recommendations

APPENDICES	**Appendix 1: Audit Committee Annual Report**

3. RECOMMENDATION

The Trust Board is asked to **NOTE** the contents of this report.

AUDIT COMMITTEE

ANNUAL REPORT 2021

Audit Committee
Annual Report 2021

1. Foreword

I am pleased to present the Annual Report of the Velindre University NHS Trust Audit Committee. It outlines the coverage and results of the Committee's work for the year ending 31 December 2021.

During the year, I was supported by Independent Members, Mr Gareth Jones and Mrs Jan Pickles, who offered considerable knowledge and wide-ranging experience to the Committee. I would like to take this opportunity to put on record my sincere thanks for the significant contribution made by both during the year.

I would like to express my thanks to all the Officers of the Committee who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by Internal Audit at NHS Wales Shared Services Partnership, Local Counter Fraud Services and by Audit Wales.

Despite a very challenging year due to the pandemic, meetings have been well attended, and there was constructive dialogue and challenge throughout. All meetings have been held virtually and have generally worked well. A characteristic of the Committee's work and its related meetings has been the willingness of all parties to raise issues, acknowledge shortcomings and put forward positive suggestions to help bring about meaningful improvements to services, systems, and day-to-day working practices. This approach is to be welcomed and is very much appreciated by the Committee.

Going forward, the Committee intends to continue to pursue a full programme of work covering a wide range of topics and subject areas as part of its long-term aim to help further strengthen the governance arrangements of the Trust, in order to achieve better value for money and high quality, sustainable outcomes for NHS Wales.

Martin Veale JP
Chair of the Velindre University NHS Trust Audit Committee
22 December 2021

2. Introduction

This report summarises the key areas of business activity undertaken by the Committee between January and December 2021 and highlights some of the key issues which the Committee intends to give further consideration to over the next 12 months.

This report reflects the Committee's key role in the development and monitoring of the governance and assurance framework within which the Trust operates.

3. Role and Responsibilities

The primary purpose of the Audit Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place – through the design and operation of the Trust's system of assurance – to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Board and the Accountable Officer on where and how its system of assurance may be strengthened and developed further.

The Trust operates a separate Audit Committee to provide assurance on the work of the NHS Shared Services Partnership (NWSSP). Whilst the same Independent Members sit on both committees, they are entirely separate, and the NWSSP Audit Committee produces its own Annual Report.

During the period ended 31st March 2021, the Committee also advised and assured the Board on those activities undertaken by the NHS Wales Informatics Service (NWIS) that were the responsibility of the Trust. NWIS left the Trust on 1st April 2021 and became a new Special Health Authority, Digital Health and Care Wales (DHCW).

4. Agenda Planning Process

The Chair of the Committee, in conjunction with the Trust's Executive Director of Finance, draws up the agenda for Committee meetings, which is based upon an agreed annual programme of work and clearly linked to the Committee's Terms of Reference.

The agenda and papers are disseminated to Committee members at least five working days before the date of the meeting.

5. Operating Arrangements

The Committee's Terms of Reference are reviewed annually, with the next review being considered at the January 2022 Audit Committee. A copy of the Terms of Reference extant at the point of writing this report is attached at the end.

The Audit Committee Cycle of Business for June 2021 to May 2022 was approved in March 2021 and will next be reviewed in April 2022. The agenda of each meeting, however, is sufficiently flexible to allow the committee to consider any emerging issues.

6. Membership, Frequency and Attendance

The Terms of Reference of the Committee state that the Committee should consist of a minimum of three Independent members of the Board. One of these members must also be a member of the Quality & Safety Committee.

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise. During 2021 this option was not exercised.

During the year the Committee met on five occasions with attendance as follows:

Name	**Audit Committee (out of 5 possible meetings)**
Mr Martin Veale JP (Independent Member) Chair	5 out of 5
Mr Gareth Jones (Independent Member)	5 out of 5
Mrs Janet Pickles (Independent Member)	4 out of 4 (tenure ended prior to 5th meeting)

During the year, the meetings were also regularly attended by the following:

- Mr Steve Ham, Chief Executive
- Mr Mark Osland, Executive Director of Finance (who left the Trust in September 2021)
- Mr Matthew Bunce, as Deputy Director of Finance until he took up the position of Executive Director of Finance in September 2021
- Ms Claire Bowden, Head of Financial Operations
- Mrs Lauren Fear, Director of Corporate Governance

- Mr Steve Wyndham, Audit Wales
- Mrs Kate Febry, Audit Wales

- Mr James Quance, Internal Audit
- Mrs Jayne Gibbon, Internal Audit

- Mr Nigel Price, Local Counter Fraud Specialist

Despite the continuing COVID-19 pandemic, the Audit Committee met as scheduled; albeit virtually through video conferencing. The Committee's 2nd meeting of the year which had previously been held in April was brought forward to March to review matters regarding the NWIS transfer prior to the effective date of 1st April 2021.

7. Audit Committee Activity 2021

The Audit Committee fulfilled its planned work for 2021 covering a wide range of activity. This work can be summarised under the following headings:

7.1 External Audit

- The Committee approved the Audit Wales plan for 2021 in March 2021. Updates from representatives from Audit Wales were given at each meeting.
- Audit Wales documentation was provided to the Committee during the year in relation to the:
    - Annual Audit Plan 2021;
    - Financial Audit 2020/2021;
    - Structured Assessment 2021;
    - Procuring & Supplying of PPE for the COVID-19 pandemic;
    - Test, Trace, Protect in Wales;
    - Audit Fee charged to the Trust.

- Audit Wales provided the Committee with a report entitled "Doing it Differently, Doing it Right?" that related to Governance in the NHS during the COVID-19 crisis and described key themes, lessons & opportunities.
- Audit Wales also shared with the Committee other relevant publications that were of relevance to the Trust.

7.2 Internal Audit

- The Committee received regular progress reports from the Internal Audit team during the calendar year following agreement of an Internal Audit Plan for 2021/2022 in March 2021, noting that it could be subject to change.
- During the year the Committee considered eighteen reports completed by Internal Audit: their assurance ratings are shown below, with a full list of the reports shown in appendix 1.

	Velindre	**NWIS**
Substantial	7	0
Reasonable	10	1
Limited	0	0
	17	**1**

- Internal Audit's annual assurance opinion for 2020/2021 was reported to the Committee in June 2021. It stated that "the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact** on residual risk exposure until resolved".

7.3 Annual Accounts, Annual Governance Statement & Accountability Report

- The Committee meeting in June 2021 received the audited 2020/2021 Annual Accounts, Annual Governance Statement, Letter of Representation and the Trust's response to Audit Wales regarding governance arrangements.
- The Annual Accounts were subject to a Qualified Audit Opinion by Audit Wales as a result of their non-attendance at stock takes, and therefore their inability to obtain sufficient appropriate evidence to support the inventory balance at the end of the financial year.
- The Committee, while expressing disappointment at the Qualified Audit Opinion, endorsed and recommended the approval of the Annual Accounts and other documents to the Trust Board.

7.4 Counter Fraud

- The Committee received the Annual Workplan for 2021/2022 in March 2021, and quarterly updates from the Counter Fraud Specialist.
- Information relevant to the National Fraud Initiative Exercise that the Counter Fraud Specialist leads on behalf of the Trust was also shared.

7.5 Internal Assurance & Risk Management Monitoring

- The Committee received details of the changes to the pro-forma and process for approval of expenditure over the Chief Executive's financial limit.
- A presentation was given to the Committee in March 2021 by the Head of Procurement detailing how the Well-Being of Future Generations Act is informing procurement in Wales.
- The Committee endorsed for Board approval a revised set of Standing Orders and Standing Financial Instructions, following a review conducted and revised model documents issued in accordance the Welsh Ministers' powers of delegation contained within certain sections of the NHS (Wales) Act 2006.

- Governance lessons that can be learnt from the response to COVID-19 were shared with the Committee.
- A Committee self-assessment questionnaire was issued in November 2021 for completion by Members and attendees, with findings to be reported in early 2022.
- Procurement Compliance was reported regularly to the Committee.
- The Trust Risk Register was presented at the July meeting for review by the Committee, noting that more detailed reviews took place in the relevant Committee and Divisional meetings.
- The Audit Action plan, which tracks the implementation of the recommendations of audit, was regularly reviewed by the Committee. The Committee at times expressed disappointment at a lack of updates provided or items overdue for implementation which were fed back to action leads accordingly.

7.6 Clinical Audit

- The Clinical Audit Annual Report was presented to the Committee by the Executive Medical Director in October 2021.

7.7 NHS Wales Informatics Service (NWIS)

- Regular updates on governance and financial matters were provided to the Committee prior to the transfer of NWIS to a new Strategic Health Authority, Digital Health and Care Wales (DHCW) on 1st April 2021.
- Specific items relating to the transfer were provided to both the January and March 2021 meetings, with closure reports provided where necessary, and offers of support to the new organisation given as appropriate.

8. Reporting the Committee's Work

The Chair of the Audit Committee reports to the Board on the key issues discussed at each meeting by way of a written Highlight Report. These reports are supported by the more detailed Committee minutes. Committee papers and committee minutes are routinely published on the Trust's website.

9. Conclusions and Way Forward

The work of the Audit Committee in 2021 has been varied and wide-ranging. The Committee's programme of work will continue to be reviewed to ensure that its contribution to governance, risk management, financial management, counter fraud and internal control is maximised.

This report demonstrates that the Audit Committee has fulfilled its terms of reference and significantly contributed to improving internal control within the Trust.

The Committee can provide the Board with assurance that, by addressing its terms of reference, it has scrutinised the levels of control in place and that where necessary has recommended improvements to controls.

Appendix 1

Levels of Assurance Assigned by Internal Audit

Substantial Assurance	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk exposure.**
Reasonable Assurance	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited Assurance	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

List of Internal Audits Undertaken and Assurance Ratings

Velindre University NHS Trust

Internal Audit Assignment	Assurance Rating 2021
Financial Systems	Reasonable
Nursing Staffing Levels Act (Wales) 2016	Substantial
Velindre Cancer Centre	Reasonable
Welsh Blood Service	Reasonable
*Workforce Planning **Follow Up***	*Reasonable*
*IM&T Control & Risk Assessment **Baseline Review***	*N/A*
New Contracting Model	Substantial
New Velindre Cancer Centre Development Advisors	Reasonable
New Velindre Cancer Centre Development Contract Arrangements / Project Agreement	Substantial
New Velindre Cancer Centre Development Governance & Financial Management	Substantial
New Velindre Cancer Centre Development Planning	Substantial
Radiotherapy Bookings	Substantial
Health & Care Standards	Substantial

Welsh Language Standards	Reasonable
Digital Health & Care Record for Cancer (CANISC Replacement)	Reasonable
Waste Management	Reasonable
Infection Prevention & Control	Reasonable
Divisional Review – Incident Management	Reasonable
Divisional Review – Risk Management	Reasonable
SUMMARY (excluding advisory & follow up reports)	
Substantial	7
Reasonable	10
Limited	0
Total	17

NWIS (to 31st March 2021)

Internal Audit Assignment	**Assurance Rating 2021**
General Data Protection Regulation ***Follow Up***	*Substantial*
Organisational Resilience	Reasonable
Governance Arrangements during the COVID-19 Pandemic ***Advisory Review***	*N/A*
SUMMARY (excluding advisory & follow up reports)	1
Substantial	0
Reasonable	1
Limited	0
Total	1

Audit Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2020
Approved:	November 2020
Next Review Due:	October 2021

1. INTRODUCTION

1.1 The Trust's standing orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Audit Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

1.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference as detailed in the NHS Wales Audit Committee Handbook June 2012.

2. PURPOSE

2.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- The adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement, providing reasonable assurance on:

  - the organisation's ability to achieve its objectives,

  - compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government and others,

  - the reliability, integrity, safety and security of the information collected and used by the organisation,

  - the efficiency, effectiveness and economic use of resources, and

- the extent to which the organisation safeguards and protects all its assets, including its people to ensure the provision of high quality, safe healthcare for its citizens;

- The Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

- The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;

- The Schedule of Losses and Compensation;

- The planned activity and results of internal audit, external audit, clinical audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);

- The adequacy of executive and managements' response to issues identified by audit, inspection and other assurance activity via monitoring of the Trust's audit action plan;

- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and

- Any particular matter or issue upon which the Board or the Accountable Officer may seek advice from the Committee.

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by reviewing:

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances), prior to endorsement by the Board;

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and

- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the NHS Counter Fraud Authority.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from other assurance providers, regulators, directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 This will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

- The comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and

- The reliability and integrity of these assurances.

3.5 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- There is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There is an effective clinical audit function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees through the effective completion of Audit Recommendations and the Committee's review of the development and drafting of the Trust's Annual Governance;

- The work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- The work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

- The systems for financial reporting to the Board, including those of budgetary control, are effective; and that

- The results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Committee will follow and implement the Audit Committee's Annual Work plan and will be evidenced through meeting papers, formal minutes, and highlight reports to Board and annually via the Annual Governance Statement and Annual Report to the Board.

Authority

3.6 The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.

3.7 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.8 The Committee is authorised by the Board to approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.9 The Head of Internal Audit and the Auditor General for Wales and his representatives shall have unrestricted and confidential access to the Chair of the Audit Committee at any time, and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

3.10 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.11 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.12 The Committee may, subject to the approval of the Trust Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) members, comprising:

Chair	Independent member of the Board (Non-Executive Director)
	Two independent members of the Board (Non-Executive Directors)
	[one member should be a member of the Quality, Safety & Performance Committee]

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

4.2 In attendance:

Chief Executive (*who should attend once a year as a minimum to discuss with the Committee the process for assurance that supports the Annual Governance Statement.)*
Executive Director of Finance
Director of Corporate Governance
Chief Operating Officer
Head of Internal Audit
Local Counter Fraud Specialist
Representative of the Auditor General for Wales

By invitation — The Committee Chair may invite:

- the Chair of the organisation
- any other Trust officials; and/or
- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.3 Secretary — As determined by the Director of Corporate Governance

Member Appointments

4.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.5 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

4.6 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Workforce & Organisational Development.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the Committee.

Frequency of Meetings

5.2 Meetings shall be held no less than 4 times per year, and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business. The External Auditor or Head of Internal Audit may request a meeting with the Chair if they consider that one is necessary.

Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, the Board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board by taking into account:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and sub Committees to meet its responsibilities for advising the Board on the adequacy of the Trust's overall system of assurance by receipt of their annual work plans.

6.5 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable

Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;

- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.

7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum *[as per section on Committee meetings]*
- Notice of meetings
- Notifying the public of Meetings
- Admission of the public, the press and other observers

Cross reference with the Trust Standing Orders.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee, after first consulting with two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	27/1/22

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Interim Vice-Chair and Chair of the Strategic Development Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	
AOS	Acute Oncology Service
IMTP	Integrated Medium-Term Plan
JET	Joint Executive Team
MIM	Mutual Investment Model
WBS	Welsh Blood Service

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Strategic Development Committee held on 8th November 2021.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Trust Board.
ADVISE	**Integrated Medium-Term Plan: Update** An update was provided to the Strategic Development Committee regarding the progress and development of the Integrated Medium-Term Plan (IMTP). **Nuffield Trust Recommendations: Progress** A progress update was provided to the Strategic Development Committee regarding the Nuffield Trust Recommendations.
ASSURE	**Trust Strategy Update** An update was given on the Trust Strategy including the various components: • Sustainability Strategy Update • Estates Strategy Update • Digital Strategy Update • People Strategy Update • Decarbonisation Plan **Velindre @ UHW – Service Specification** A presentation was delivered to the Strategic Development Committee regarding the Velindre @ UHW Service Specification by Dr Mererid Evans and Phil Hodson. The presentation provided the Strategic Development Committee with the draft proposal for a tripartite Cardiff Cancer Research Hub at the University Hospital of Wales (UHW), Cardiff. The draft proposal is a tripartite partnership between Cardiff and Vale University Health Board (CAVUHB), Cardiff University (CU) and Velindre University NHS Trust (VUNHST). This will further develop the research and development (R&D) infrastructure in Wales further through the establishment of a joint Cancer Research Hub to make Cardiff, and indeed Wales, competitive on the UK cancer research stage.

INFORM	There were no items identified to Inform the Trust Board.
APPENDICES	None.

TRUST BOARD

BRACHYTHERAPY SERVICE

DATE OF MEETING	27/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kathy Ikin, Head of Radiation Services
PRESENTED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Interim Chief Operating Officer

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
WHSSC	Welsh Health Specialised Services Committee
VCC	Velindre Cancer Centre
IGBT	Image Guided Brachytherapy

1. SITUATION/BACKGROUND

1.1 The Brachytherapy service is being reviewed and developed due to a number of factors. This paper provides an overview of the issues being experienced and the actions underway to address them. This includes capacity and demand, commissioning, quality standards, service resilience, staff model and service management.

1.2 The service is delivered in a multi-disciplinary model, with staff groups spanning consultant oncologists, anesthetists, allied health professionals, healthcare science and other support services. Brachytherapy service has a fragmented management reporting structure.

1.3 The service has evolved over a period of time and due to the multidisciplinary nature this has not been a cohesive approach and there are workforce gaps. A number of incidents have occurred relating to Brachytherapy which has identified a gap between the current service and the national standard

1.4 A task and finish Brachytherapy Project Board (covering Gynae & Prostate) established in August 2021 to oversee a comprehensive safety focused review of service chaired by the Executive Director Nursing, AHP & Health Science.

1.5 A business case is being finalised to secure ongoing funding for the current service as well as to introduce a new High Dose Rate (HDR) prostate service.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Capacity, Demand and Commissioning

2.1.1 Specialist Brachytherapy is a super-regional service and is funded directly via WHSSC. VCC is the only Centre in South Wales delivering Brachytherapy and interfaces with the referral pathways of 6 Health Board. The service provides treatment for a range of tumour sites with the highest demand for gynaecological and urological indications. For some patients Brachytherapy is the first definitive treatment.

2.1.2 The COVID 19 pandemic has resulted in significant fluctuations in demand as referral clinics have impacts on their operations with an associated impact on the pattern of patients coming to VCC.

2.1.3 Referrals to the service now exceed the commissioned volumes and this is exacerbated by the "block contract" arrangements that have been maintained during the pandemic and a new business case is in development.

2.1.4 This specialist service has a limited level of resilience as the historic resourcing model has been designed to meet demand on an annualised basis. This does not provide sufficient resource to meet significant demand fluctuations which have been experienced since the start of the pandemic.

2.1.5 The demand for Image Guided Brachytherapy (IGBT) for gynaecology patients and prostate patients has increased significantly against the 2019 block-contracting model.

2.1.6 The demand increase for IGBT also represents an increase in acuity of patients, which has been reported by Health Boards as a result of delayed patient presentation to GP's, diagnostic imaging and other systemic backlogs.

2.1.7 Robust demand forecasting is in place, to develop a revised business case with WHSSC to increase resourcing.

2.2 Service delivery – quality standards and workforce modelling

2.2.1 Under the oversight of the Brachytherapy Project Board, a comprehensive work plan has been established and is being delivered. The objective is to define a revised service delivery specification & model with defined workforce model and resilient forward capacity plan as well as a comprehensive workforce development plan.

2.2.2 A new Brachytherapy lead role has been established and is being advertised and an operational management group put in place to lead service delivery across the elements of the service.

2.2.3 A Patient pathway review is planned but has been delayed due to wave 4 but will now be planned for the end Feb 22.

2.2.4 A peer review has been commissioned from Clatterbridge Cancer Centre (CCC) the purpose of which is to assess a 'value for money service model', identify opportunities for improvement to the patient experience and share learning.

2.2.5 The review was planned for January 2022, however has been postponed due to pandemic pressures in both centres. We will meet with CCC mid-February to urgently determine a new date.

2.2.6 VCC has a project board structure in place to manage the review outcomes, and workforce modelling, and support the development of the business case. The

Head of Brachytherapy Service post is at present out to advert to strengthen the leadership provision moving forwards.

2.2.7 The National (NHS England) & Professional Brachytherapy standards / specification has been identified and a gap analysis is being undertaken which will then have an associated action plan.

2.2.8 A Patient Experience review is underway for all patients who received brachytherapy in last year. This is using CIVICA System.

2.2.9 A workforce review is being undertaken to address urgent capacity and resilience issues as well as to identify training and competence requirements. A longer term workforce plan will also be developed.

2.2.10 The work of the group will be monitored by the VCC Senior Leadership Group and reported to the Board via the Quality, Safety and Performance report.

3 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The working group is focused on identifying any gaps in service quality and standards and addressing them.
RELATED HEALTHCARE STANDARD	Individual Care
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

	The commissioning work will ensure we are appropriately resourced to deliver this specialist service.

4 RECOMMENDATION

4.1 The Board is requested to note this service update.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 11 JANUARY 2022

The Welsh Health Specialised Services Committee held its latest public meeting on 11 January 2022. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.
The papers for the meeting can be accessed at:

https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

1.0 Managing Director's Report

Members received the Managing Director's Report and **noted** updates on:

- **Ty Llewellyn Medium Secure Unit** - The assurance review undertaken by the National Collaborative Commissioning Unit (NCCU) Quality Assurance Service in the Ty Llewellyn Male Medium Secure Unit at Betsi Cadwaladr University Health Board (BCUHB) and the future requirement for an action plan from the Health Board; and
- **System Resilience and the Local Options Framework Impact – Weekly Reporting** - As a consequence of challenges in achieving quoracy, linked to COVID-19 operational pressures at Health Board (HB) level, and the recent letter from Mrs Judith Paget CEO of NHS Wales suggesting NHS bodies step down any non-essential meetings, the panel have returned to the process previously adopted during the start of the pandemic to ensure business continuity. The full IPFR Panel meeting will be stood down for January 2022, and the Chair's action arrangement outlined in the Terms of Reference (ToR) will be used, strengthened by including the attendance of two WHSSC Clinical Directors and a lay member representative. Therefore, the strengthened Chair's Action option for Panel decisions will be used during January 2022 instead of the full Panel. Members **noted** that an update report will be presented to the Joint Committee on 18 January 2021.

Members **noted** the report.

2.0 Integrated Commissioning Plan (ICP) 2022-2025

Members received the WHSSC Integrated Commissioning Plan (ICP) 2022-2025 for approval and were requested to approve its submission to Welsh Government (WG) in line with the requirements set out in the WG Planning Guidance.

Members noted that:

- In November 2021 the Joint Committee (JC) had requested that an extraordinary JC meeting be held on 11 January 2022 to approve the WHSSC Integrated Plan (ICP) ahead of Health Board (HB) Integrated Medium Term Plans (IMTP's) being submitted to Boards for approval;
- The Management Group (MG) met on 6 December 2021 and were advised that it may be necessary for MG to convene an ad hoc meeting in early January 2022 for further discussion of the ICP once the HBs had received their financial allocation letters from Welsh Government (WG) and that they would contact the WHSS team with any issues arising from the allocation letters as required; and
- Following the December meeting no formal contact had been received from any MG members to request an ad hoc meeting, however informal feedback had been received from some HBs advising that they may not be in a position to provide final sign off of the ICP at present as they were still working on their own IMTPs.

Members **discussed** the challenges for HBs related to the allocation letter and the increasing levels of uncertainty regarding the recovery position and the risks that this posed. Members **noted** that HBs were still working through their own plans and may not be able to commit to fully approving the ICP at this point, and agreed that the ICP be approved in principle subject to further work being completed with the MG to further explore the risk appetite and specifically the potential for further financial slippage that could reduce the increase needed for the first year of the ICP whilst maintaining a prudent view of the recurrent position. The WHSSC team indicated that the potential for further slippage had already been identified by the team and would be shared in advance. The areas for risk appetite review include the time lag estimated for new developments to fully account for manpower shortages and recovery rate uncertainty, recognising that some new developments may need to brought on more quickly than others. The scale of the potential reduction in the year 1 requirement was indicated to be a reduction to circa 5.11% from the current 6.57%.

Members (1) **Approved** the Integrated Commissioning Plan (ICP) 2022-2025 **in principle** as the basis of the information to be included in the Health Board IMTP's, and **agreed** to refer the ICP back to the

Management Group meeting on 20 January 2022 for further discussion on the financial allocation and tables, and that a special extraordinary JC meeting be scheduled in February 2022 to formally approve the plan in readiness for submission to Welsh Government by the end of February deadline.

VELINDRE UNIVERSITY NHS TRUST

PUBLIC TRUST BOARD MEETING
ACTION LOG

25 NOVEMBER 2021				
MINUTE NUMBER	**ACTION**	**LEAD**	**STATUS**	**DUE DATE/ STATUS**
5.1.0	**Chair's Update**			
	Prof Donna Mead to circulate her new objectives to the Independent Members once finalised and agreed with the Minister.	**DM**	**OPEN**	**TBC**
6.1.0	**Quality, Safety & Performance Committee Highlight Report**			
	Nicola Williams to circulate the full patient and donor experience survey following Welsh translation to Independent Members.	**NW**	**OPEN**	**TBC**
6.3.0	**Delivering Excellence Performance Report Period September 2021**			
	Cath O'Brien to update Prof Donna Mead on the development of the WHSSC Brachytherapy Business Case outside of the meeting.	**COB**	**CLOSE**	Paper produced for January Trust Board, Cath O'Brien to discuss with the Chair as part of January 1-1 meeting.
	Cath O'Brien to provide an update on the WHSSC Brachytherapy Business Case at the January Trust Board.	**COB**	**CLOSE**	Update has been provided and included on January Trust Board Agenda for noting.
6.6.0	**Velindre University NHS Trust Clinical Audit Report 2020/21**			
	Regular Clinical Audit Plan updates to be scheduled into the Audit Committee Annual Cycle of Business.	**JA**	**CLOSE**	This has been added to the Audit Committee Cycle of Business
7.1.0	**Equality Ambassadors Showcase: Religion & Belief**			
	Prof Donna Mead to contact Prof Linda Ross regarding the work of the European Group in the development of spiritual competencies.	**DM**	**OPEN**	

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Audit Wales

Annual Audit Report 2021 – Velindre University NHS Trust

Audit year: 2020-21

Date issued: December 2021

Document reference: 2742A2021-22

This document has been prepared for the internal use of Velindre University NHS Trust as part of work performed/to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting to the Senedd on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Contents

Summary report

About this report

1 This report summarises the findings from my 2021 audit work at Velindre University NHS Trust (the Trust) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Trust;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts
- Arrangements for securing economy, efficiency and effectiveness in the use of resources

3 This year's audit work took place at a time when public bodies continued responding to the unprecedented challenges presented by the COVID-19 pandemic, whilst at the same time recovering services. My work programme was designed to best assure the people of Wales that public funds are well managed. I have considered the impact of the current crisis on both resilience and the future shape of public services. I aimed to ensure my work did not hamper public bodies in tackling the crisis, whilst ensuring it continued to support both scrutiny and learning. On-site audit work continues to be restricted, and we continued to work and engage remotely where possible through the use of technology. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

4 As was the case in 2020, the delivery of my audit of accounts work was not without its challenges, not only in how and where we undertook the work, but also in taking account as far as possible considerations for financial statements arising directly from the pandemic. Delivery of the audit reflects a collective effort by both my staff and the Trust's officers to embrace and enable new ways of working and remain flexible to and considerate of the many issues arising.

5 I have adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the crisis and to enable remote working. My programme of work has provided focus on themes, lessons and opportunities relating to NHS governance and NHS staff wellbeing. I have reviewed the rollout of the COVID-19 vaccine. My local audit teams have commented on how governance arrangements have adapted to respond to the pandemic, and the impact the crisis has had on service delivery.

6 This report is a summary of the issues presented in more detailed reports to the Trust this year (see **Appendix 1)**. I also include a summary of the status of planned work currently being re-scoped.

7 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2021 Audit Plan.

8 **Appendix 3** sets out the financial audit risks set out in my 2021 Audit Plan and how they were addressed through the audit.

9 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. We presented it to the Audit Committee on 11 January 2022. The Board will also receive the report. We strongly encourage the Trust to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

10 I would like to thank the Trust's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

11 I concluded that the Trust's accounts were properly prepared and materially accurate with the exception of the Trust's inventory balance, as at 31 March 2021, of £95.564 million. As a result of the pandemic we were unable to obtain the necessary audit evidence, as mandated by professional Auditing Standard ISA501 for material inventory balances, and so issued a qualified 'limitation of scope' opinion. This qualification was not due to any shortcomings in the Trust's systems or actions and my work did not identify any material weaknesses in the Trust's internal controls (as relevant to my audit). In addition, I placed an Emphasis of Matter paragraph in my report to draw attention to disclosures in the accounts in note 24 relating to the impact of a Ministerial Direction issued on 18 December 2019 to the Permanent Secretary of the Welsh Government concerning Clinicians' Pension Tax Liabilities.

12 I identified no material financial transactions within the Trust's 2020-21 accounts that were not in accordance with authorities or not used for the purpose intended, and so I have issued an unqualified opinion on the regularity of the financial transactions within the Trust's 2020-21 accounts.

13 The Trust achieved financial balance for the three-year period ending 31 March 2021. The Trust has an approved three-year plan in place. I placed a substantive report on the Trust's financial statements to set out further detail on the Emphasis of Matter paragraph that I included in my audit opinion.

Arrangements for securing efficiency, effectiveness and economy in the use of resources

14 My programme of Performance Audit work has led me to draw the following conclusions:

- the COVID-19 vaccination programme in Wales has been delivered at significant pace with local, national and UK partners working together to vaccinate a significant proportion of the Welsh population. A clear plan is now needed for the challenges which lie ahead.
- all NHS bodies have maintained a clear focus on staff wellbeing throughout the pandemic and implemented a wide range of measures to support the physical health and mental wellbeing of their staff during the crisis. It is vital that these activities are built upon, and that staff wellbeing remains a central priority for NHS bodies as they deal with the combined challenges of recovering services, continuing to respond to the COVID-19 pandemic, and also managing seasonal pressures.
- the Trust's arrangements for developing operational plans and monitoring their delivery are effective and have the flexibility to respond to changing circumstances.
- the Trust has good arrangements to conduct Board and committee business effectively, but opportunities to enhance public transparency remain.
- the Trust achieved its financial duties at the end of 2020-21 and has a clear financial plan to deliver and services in 2021-22.

15 These findings are considered further in the following sections.

Detailed report

Audit of accounts

16 This section of the report summarises the findings from my audit of the Trust's financial statements for 2020-21. These statements are how the organisation shows its financial performance and sets out its net assets, net operating costs, recognised gains and losses, and cash flows. Preparing the statements is an essential element in demonstrating the appropriate stewardship of public money.

17 My 2021 Audit Plan set out the financial audit risks for the audit of the Trust's 2020-21 financial statements. **Exhibit 4** in **Appendix 3** lists these risks and sets out how they were addressed as part of the audit.

18 My responsibilities in auditing the Trust's financial statements are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2020-21 financial statements

19 I concluded that the Trust's accounts were properly prepared and materially accurate with the exception of the Trust's inventory balance, as at 31 March 2021, of £95.564 million. As a result of the pandemic, we were unable to obtain the necessary audit evidence, as mandated by professional Auditing Standard ISA501 for material inventory balances, and so issued a qualified 'limitation of scope' opinion. This qualification was not due to any shortcomings in the Trust's systems or actions and my work did not identify any material weaknesses in the Trust's internal controls (as relevant to my audit). In addition, I placed an Emphasis of Matter paragraph in my report to draw attention to disclosures in the accounts in note 24 relating to the impact of a Ministerial Direction issued on 18 December 2019 to the Permanent Secretary of the Welsh Government concerning Clinicians' Pension Tax Liabilities.

20 The Trust submitted its draft accounts within the required deadline. The accounts, and supported working papers, were of good quality, and officers of the Trust provided us with an appropriate level of support and engagement, in what where challenging circumstances, to enable us to complete the audit on a timely basis.

21 I must report issues arising from my work to those charged with governance before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues to the Trust's Audit Committee on 8 June 2021. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues identified in the Audit of Financial Statements Report

Issue	Auditors' comments
Uncorrected misstatements	Uncertainty existed in relation to a number of Welsh Risk Pool Structured Settlement cases where there was insufficient evidence to support the provision value of £20.5 million concerning these cases. We were satisfied that any potential over-statement of the provision value was not material to our opinion.
Corrected misstatements	There were some misstatements in the accounts that were corrected by management.
Other significant issues	Other than the Emphasis of Matter commented upon above no other significant issues were identified.

22 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Trust's financial position as at 31 March 2021 and the return was prepared in accordance with the Welsh Government's instructions.

23 My separate audit of the charitable funds financial statements is currently ongoing and we anticipate this audit being completed by the Charity Commission deadline of 31 January 2022.

Regularity of financial transactions

24 I identified no material financial transactions within the Trust's 2020-21 accounts that were not in accordance with authorities or not used for the purpose intended, and so I have issued an unqualified opinion on the regularity of the financial transactions within the Trust's 2020-21 accounts.

25 The Trust's financial transactions must be in accordance with the authorities that govern them. It must have the powers to receive the income and incur the expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Trust does not have the powers to receive or incur.

26 The Trust achieved financial balance for the three-year period ending 31 March 2021. The Trust has an approved three-year plan in place. I placed a substantive report on the Trust's financial statements to set out further detail on the Emphasis of Matter paragraph that I included in my audit opinion.

Arrangements for securing efficiency, effectiveness and economy in the use of resources

27 I have a statutory requirement to satisfy myself that the Trust has proper arrangements in place to secure efficiency, effectiveness and economy in the use of resources. I have undertaken a range of performance audit work at the Trust over the last 12 months to help me discharge that responsibility. This work has involved:

- reviewing how well the rollout of the COVID-19 vaccination programme was progressing;
- reviewing how NHS bodies supported staff wellbeing during the COVID-19 pandemic; and
- undertaking a phased structured assessment of the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively and economically.

28 My conclusions based on this work are set out below.

COVID-19 vaccination programme

29 In June 2021, I published the findings from my initial review of the rollout of the COVID-19 vaccination programme in Wales. My work considered the factors that affected the rollout and future challenges and opportunities.

30 I found that the vaccine programme has been delivered at significant pace. At the time of reporting, vaccination rates in Wales were the highest of the four UK nations, and some of the highest in the world. The milestones in the Welsh Government's vaccination strategy provided a strong impetus to drive the programme and up to the time of reporting, the key milestones had been met.

31 The UK's Joint Committee on Vaccination and Immunisation guidance on priority groups was adopted but the process of identifying people within some of those groups has been challenging.

32 The organisations across Wales involved in the rollout have worked well to set up a range of vaccination models which make the best use of the vaccines available, while also providing opportunities to deliver vaccines close to the communities they serve.

33 Overall vaccine uptake to the time of reporting was high, but there was a lower uptake for some ethnic groups and in the most deprived communities. At the time of the audit, vaccine wastage was minimal, but concerns were emerging about non-attendance at booked appointments.

34 The international supply chain is the most significant factor affecting the rollout, with limited vaccine stock held in Wales. However, increasing awareness of future supply levels was allowing health boards to manage the vaccine rollout effectively.

35 As the programme moved into the second half of 2021, challenges presented themselves around encouraging take-up amongst some groups, vaccine workforce resilience and venue availability. I identified the need for a longer-term plan across Wales to address these challenges and other elements of the ongoing vaccination programme[1].

How NHS bodies supported staff wellbeing during the COVID-19 pandemic

36 My review considered how NHS bodies in Wales have supported the wellbeing of their staff during the pandemic, with a particular focus on their arrangements for safeguarding staff at higher risk from COVID-19.

37 NHS staff have shown tremendous resilience and dedication throughout the pandemic, despite facing huge strains to their mental and physical health.

38 The NHS in Wales was already facing a number of challenges relating to staff wellbeing prior to the pandemic, and the crisis has highlighted the importance of supporting the mental and physical health of the NHS workforce. Through my Structured Assessment work, I found that NHS bodies moved quickly at the beginning of the pandemic to enhance wellbeing initiatives to support staff through unprecedented times. As the pandemic unfolded, I found that NHS bodies in Wales implemented a range of measures to improve staff wellbeing, such as creating dedicated rest spaces, increasing mental health and psychological wellbeing provision, enhancing infection and prevention control measures, and enabling remote working.

39 My work also looked at how NHS bodies in Wales protected staff at higher risk from COVID-19. Amongst other safeguarding initiatives, I found that all bodies rolled out the All-Wales COVID-19 Workforce Risk Assessment Tool which identifies those at a higher risk and encourages a conversation about additional measures to be put in place to ensure staff are adequately protected. Although NHS bodies promoted and encouraged staff to complete the assessment tool, completion rates varied between NHS bodies.

40 While the crisis has undoubtedly had a considerable impact on the wellbeing of staff in the short term, the longer-term impacts cannot be underestimated.

41 With a more emotionally and physically exhausted workforce than ever, NHS bodies in Wales must maintain a focus on staff wellbeing and staff engagement to navigate through the longer-term impacts of the crisis. My report, therefore, is accompanied by a checklist which sets out some of the questions NHS Board members should be asking to ensure their health bodies have good arrangements in place to support staff wellbeing.

[1] At the time of writing, the Trust's involvement in the vaccination programme has largely ceased.

Structured assessment

42 My structured assessment work was designed in the context of the ongoing response to the pandemic. I ensured a suitably pragmatic and relevant approach to help me discharge my statutory responsibilities, whilst minimising the impact on NHS bodies as they continue to respond to the pandemic. My team undertook the work into two phases this year:

- Phase 1 considered the planning arrangements underpinning the development and delivery of the operational plan for quarters three and four of 2020-21.
- Phase 2 considered how corporate governance and financial management arrangements adapted over the year. Auditors also paid attention to progress made to address previous recommendations.

Operational planning arrangements

43 My work considered the Trust's operational planning arrangements underpinning the operational plan for quarters three and four of 2020-21. The planning framework covered the maintenance of effective and efficient operational planning arrangements in health bodies to guide their response to the pandemic as well as responding to winter pressures and laying the foundations for effective recovery of services.

44 My work found that the Trust's arrangements for developing operational plans and monitoring their delivery are effective and have the flexibility to respond to changing circumstances.

45 The Trust's Quarters' Three-Four Plan 2020-21 (the Quarters' 3-4 Plan) was submitted to the Welsh Government within the required timeframe, covers all necessary areas within the planning framework guidance and received the required Board scrutiny.

46 The Trust has maintained the same approach for developing its quarterly plans as was the case for developing plans in previous years. The Quarters' 3-4 Plan is a progression from the previous two quarterly plans and is underpinned with the best possible information available given the uncertainty the pandemic presents. Arrangements to deliver the Quarters' 3-4 Plan are dynamic and have responded to the changing circumstances and supported the wider NHS.

47 The Trust has effective operational and strategic arrangements to monitor progress against operational plans. The Board regularly reviews progress in delivering the priorities set out in operational plans.

Governance arrangements

48 My work considered the Trust's ability to maintain sound governance arrangements while having to respond to the unprecedented challenges presented by the pandemic. The key focus of the work has been the corporate arrangements for

ensuring that resources are used efficiently, effectively, and economically. We also considered how business deferred in 2020 was reinstated and how learning from the pandemic is shaping future arrangements for ensuring continued good governance and recovery.

49 My work found that the Trust has good arrangements to conduct Board and committee business effectively, but opportunities to enhance public transparency remain.

50 The Trust has good governance arrangements which adapted well to the pandemic. The Trust has streamlined its Board committee structure, and postponed Board and committee business is being reactivated.

51 The quality and presentation of information at Board and committees is good, but on occasions, papers include content which is perhaps too detailed.

52 Transparency of Board business to the public is good, but there are some opportunities for improvements, including ensuring that video recordings and committee papers are uploaded to the website shortly after meetings.

53 The Trust has introduced improved risk management arrangements and is currently refreshing quality governance arrangements. The Trust is developing detailed plans to ensure ongoing business continuity and increase capacity to respond to increasing demand for services. However, not all strategic priorities are supported by specific, timebound actions for delivery.

Managing financial resources

54 I considered the Trust's financial performance, financial controls and arrangements for monitoring and reporting financial performance.

55 I found that the Trust achieved its financial duties at the end of 2020-21, and a clear financial plan to deliver services in 2021-22.

56 The Trust has good arrangements to manage its financial resources and continues year on year to meet its financial duties. Financial controls are effective, and the Trust uses clear, timely financial information to monitor and report its performance.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Trust in 2021.

Report	Date
Trust's 2020-21 financial statements	
Audit of Financial Statements Report	8 June 2021
Opinion on the Financial Statements	15 June 2021
Recommendations arising from our audit of the Trust's 2020-21 accounts	14 October 2021
Trust's 2020-21 charity accounts	
Audit of Financial Statements Report	22 December 2021
Opinion on the Financial Statements	6 January 2022 (planned)
Performance audit reports	
Doing it differently, doing it right? (Structured Assessment 2020 All-Wales themes, lessons and opportunities relating to NHS governance during COVID-19)	January 2021
Rollout of the COVID-19 vaccination programme in Wales	June 2021

Report	Date
Structured Assessment 2021: Phase 1 Operational Planning Arrangements	May 2021
Taking care of the carers? (Structured Assessment 2020 All-Wales themes, lessons and opportunities relating to NHS staff wellbeing during COVID-19)	October 2021
Structured Assessment 2021: Phase 2 Corporate Governance and Financial Management Arrangements	December 2021
Other	
2021 Audit Plan	March 2021

My wider programme of national value for money studies in 2021 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are a number of performance audits that are still underway at the Trust. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Quality governance review (2020 Audit Plan)	April 2022
Local work (2021 Audit Plan)	April 2022

Appendix 2

Audit fee

The 2021 Audit Plan set out the proposed audit fee of £227,996 (excluding VAT). My latest estimate of the actual fee, on the basis that some work remains in progress, is in keeping with the fee set out in the outline.

In addition to the fee set out above, the audit work undertaken on the shared services provided to the Trust by the NHS Wales Shared Services Partnership cost £2,225.

Appendix 3

Financial audit risks

Exhibit 4: financial audit risks

My 2021 Audit Plan set out the financial audit risks for the audit of the Trust's 2020-21 financial statements. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.	Planned audit work completed and no issues arising.

Audit risk	Proposed audit response	Work done and outcome
The increased funding streams and expenditure in 2020-21 to deal with the COVID-19 pandemic will have a significant impact on the risks of material misstatement and the shape and approach to our audit. In particular, the Trust and NWSSP have been integral in procuring and distributing PPE in response to the pandemic. The Trust has received in excess of £230 million funding from the Welsh Government to procure PPE to supply Welsh NHS bodies and social care providers. PPE was also supplied to other UK bodies. There are potential risks concerning the fact that much of the expenditure was incurred quickly and was approved via streamlined governance processes, as well as the accounting treatment of this arrangement, including the valuation of the related year-end inventory balance.	We will identify the key issues and associated risks and plan our work to obtain the assurance needed for our audit.	The Trust and Shared Services received significant additional funding from the Welsh Government as a result of the pandemic. Whilst this generated added complexity to the accounts and the disclosures, and to our audit, no significant issues arose and we were able to draw the necessary assurance for our opinion. Related to this however, as a result of the pandemic we were unable to obtain the necessary audit evidence, as mandated by professional Auditing Standard ISA501 upon the Trust's material inventory balances, of £95.564 million, and so issued a qualified 'limitation of scope' opinion. It is important to emphasise that this qualification was not due to any shortcomings in the Trust's systems or actions, but because of the impact of COVID-19 on one of our key audit procedures.

Audit risk	Proposed audit response	Work done and outcome
NHS Trusts have a financial duty to break even over a three-year rolling period. Although the Trust is forecasting a break-even position for the year-end, this duty increases the risk that management judgements and estimates included in the financial statements could be biased in helping to achieve this financial duty. Where the Trust fails this financial duty, I will place a substantive report on the financial statements highlighting the failure.	The audit team will focus its testing on areas of the financial statements which could contain reporting bias.	The Trust achieved its break even duty – no issues arising.
The COVID-19 national emergency continues and the pressures on staff resources and of remote working may impact on the preparation and audit of accounts. Whilst the remote working arrangements operated well in the prior year, a risk remains that the quality of the accounts and supporting working papers may be compromised leading to an increased incidence of errors.	We will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and monitor the accounts preparation process.	Despite the challenges posed by the pandemic, the Trust produced timely good quality accounts together with good quality working papers.

Audit risk	Proposed audit response	Work done and outcome
The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year we included an Emphasis of Matter paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. However, if any expenditure is made in year, we would consider it to be irregular as it contravenes the requirements of Managing Public Monies.	We will review the evidence one year on around the take-up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.	In common with other NHS Wales bodies, an Emphasis of Matter paragraph was included in our audit opinion concerning this matter.
Land transfers between the Trust and Cardiff and Vale University Health Board are expected to occur during 2020-21 in relation to the planned new Velindre Cancer Centre. The impact of this is expected to be material.	We will monitor progress of this and, if appropriate, review the associated accounting treatment.	The land transfer occurred during the 2020-21 financial year and evidence was obtained to provide assurance that this was appropriately accounted for within the 2020-21 financial statements.

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TRUST BOARD

CHAIR'S REPORT

Date of meeting	27/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

Prepared by	Lenisha Wright, Business Support Officer
PRESENTED BY	Professor Donna Mead, Chair
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

Committee/Group who have received or considered this paper PRIOR TO THIS MEETING		
Committee or Group	DATE	OUTCOME
N/A		

ACRONYMS	
CDRL	Component Development Research Laboratory
AHP	Allied Health Professional
RCN	Royal College of Nursing
IMTP	Integrated Medium Term Plan

1. SITUATION/BACKGROUND

This report provides information to the Board from the Chair on a number of pertinent issues. A summary of activities and engagements is included to advise of areas of focus in recent weeks and months.

1.1. Issues addressed in this report cover the following:

This Chair's gives an update on the following matters in this report:

- Board Development / Briefing Session
- Armed Forces in Wales Awards and Defence Employer Recognition Scheme Silver Awards
- MediWales Innovation Awards
- Member of the British Empire Award
- Maggie's Anniversary

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

A summary of priorities, activities, engagements and matters of interest is provided by the Chair below.

2.1. Board Development/Board Briefing Session

The Chair would like to summarise matters discussed at the latest Board Development / Board Briefing session. At the session held on 16th December 2021 the Board received input and updates on the following:

- **Safeguarding training:** Board Safeguarding and Public Protection Training including resources for Group 6 Violence against Women Domestic Abuse and Sexual Violence was presented. The training covered relevant legislation including the Social Services and Well-being (Wales) Act 2014 - Part 7. Safeguarding formed part of the session. Circulars and supporting material were provided to members in attendance.
- **Trust Strategy:** Carl James, Director of Strategic Transformation, Planning and Digital, led a further development discussion on the Trust Strategy: Destination 2032 covering the vision and strategic goals for the Trust. This reflects developments presented to Strategic Development Committee and forms part of this meeting's agenda.
- **Integrated Medium Term Plan (IMTP):** The IMTP is prepared in line with ministerial priorities, with an emphasis on immediate priorities, and the implementation and stabilisation of COVID recovery actions. A presentation was provided to members covering the following key points.
    - Capacity and demand
    - Must do work programmes
    - The Trust Financial outlook

- This also reflects developments presented to Strategic Development Committee and the IMTP will be brought through the next Committee and Trust Board for approval.
- **Performance Management Framework:** A presentation was led by Carl James, Director of Service Transformation, Planning & Digital On the next stages of development of the framework.

2.2. Armed Forces in Wales Awards and Defence Employer Recognition Scheme – Silver Awards

The Chair advises of her attendance to the of the above awards ceremony. At the event, employers from around Wales were presented with the prestigious Employer Recognition Scheme Silver Awards at the event held on the evening of November 25th. A total of 24 organisations were recognised for their support and commitment towards Defence.

2.3. MediWales Innovation Awards

The Chair advises the Board of the privilege of being invited to attend the MediWales Innovation Awards. MediWales is a life science network for Wales and has over 180 members including manufacturers, research and testing facilities, academic departments, NHS clinicians and professional services organisations. MediWales is part of the Medilink UK network and United Life Sciences.

MediWales held its 16th annual Innovation Awards dinner on 2nd December 2021 to celebrate the success of the Welsh life sciences sector, run in collaboration with Health and Care Research Wales and the Healthcare Technology, Strategy and Innovation team at Welsh Government.

2.4. Member of the British Empire Award

We are proud to announce that Dr Seema Arif, a Consultant Clinical Oncologist was awarded a Members of the Order of the British Empire (MBE) in the New Year's Honours List. The award for services to Health Care amongst the Black, Asian and Minority Ethnic Community

Together with Steve Ham, CEO, the Chair would like to offer their congratulations: "On behalf of everyone at Velindre, we want to congratulate Seema on this very well-deserved recognition. Her work in health education for BAME communities is hugely important and we are delighted that this work has been recognised."

Dr Arif's career has led her to train across the globe, including Canada and the United States. Seema is a consultant clinical oncologist at Velindre Cancer Centre and has over a decade of service with the NHS.

2.5. Maggie's Anniversary

Maggie's offers a warm, informal, supportive and welcoming space for anyone with cancer, and their families, to drop in and experience a creative programme of support. Maggie's is based on our Velindre Cancer Centre site Maggie's celebrated its 25th anniversary year on 29th November.

The Chair submitted congratulatory notes in her absence to praise the work being done and support to people living with cancer is commendable.

2.6. Donor Clinic attendance

The Chair would like to inform the committee of her attendance to a blood donor clinic on 31st December. The Chair had the opportunity afforded to thank staff who were working on New Year's Eve, with many of them having worked over the Christmas bank holiday as well.

It was impressive to see the professionalism of the staff in carrying out their duties. It was also remarkable to see less experienced staff being supported by more experienced staff. During the visit, the Chair witnessed a clinic that ran smoothly, and all infection control protocols were in place. The Chair took advantage of the opportunity to listen to donors' stories of why they make the effort to donate which was truly uplifting to hear. In one instance, one extraordinary mother of a rugby player now has the entire squad donating.

3.0 Impact Assessment

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4.0 RECOMMENDATION

4.1 The Board is asked to **NOTE** the content of this update report from the Trust Chair.

TRUST BOARD

CHIEF EXECUTIVE'S REPORT

DATE OF MEETING	27.01.2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lauren Fear, Director of Corporate Governance
PRESENTED BY	Steve Ham, Chief Executive
EXECUTIVE SPONSOR APPROVED	Steve Ham, Chief Executive

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
N/A		Choose an item.

ACRONYMS	

1. SITUATION/BACKGROUND

This report provides information to the Board from the Chief Executive.

Issues addressed in this report cover the following;

- Covid Response
- Approval of Full Business Case for Enabling Works for the new Velindre Cancer Centre
- Application for Injunction update
- Scaling up Innovation and Transformation Award
- Integrated Medium Term Plan 2022 - 2025

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Covid Response

Firstly, I would like to express my thanks on behalf of the Board to all the staff in the Trust who continue to respond to the continually changing situation within which we are having to deliver our services, for what has now been almost two years. The way in which you have responded and focused on the needs of our patients and donors has been inspiring.

Following the emergence of the new Omicron variant of Covid the Trust re-established the command structures adopted in previous waves. Clinical pathways have been reviewed and the Strategic Clinical Advisory Group has been established as part of this work. In the Quality, Safety and Performance Committee last week there was a Covid update which included an overview of the decision making framework operating through the command structure, including the clinical governance based on agreed clinical principles. The Board has agreed that the Quality, Safety and Performance Committee will meet monthly to provide an enhanced assurance role on the decisions made through the command structure.

Due to the change in national alert levels, the Executive team also agreed to close the Trust's Head Office in Nantgarw during January to reflect that all those who could were working from home.

Health and Wellbeing support for staff continues to be a core priority of the command structure decision making. Interventions were reviewed in December and continue to be available to all Velindre University NHS Trust staff, these include:

- Wellbeing webinars; support lines; tools; resources for families
- Self-Care packages including mindfulness App
- Support for financial Wellbeing
- Staff wellbeing places to recharge
- Work in Confidence – an anonymous staff feedback tool — enabling and encouraging a safe environment to raise concerns and put forward ideas.

Question and Answer Sessions were run in December providing an opportunity for staff to ask questions of Executive Board Members. The main focus was the Trust's response to the escalating COVID situation but there was an opportunity for staff to ask questions about other matters.

2.2 Approval of Full Business Case for Enabling Works for the new Velindre Cancer Centre

The CEO would like to update the Board that the Welsh Government have approved the Full Business Case for the Enabling Works for the new Velindre Cancer Centre.

The first phase of the Enabling Works is due to start from 24th January, with some site preparation beforehand. The work will last approximately eight weeks.

The first phase includes tree clearance, in line with the seasonal wildlife and habitat restrictions. No Category A trees, which are defined as trees of high quality and value capable of making a significant contribution to the area for 40 or more years, will be affected. We will not touch trees that have Tree Protection Orders and are committed to planting two trees for every tree cleared as part of the new development.

All relevant permissions have been obtained and the works will be undertaken under ecological supervision. We are continuing to communicate with local representatives and resident associations to ensure the plans are understood.

There have been staff sessions this week, both socially distanced drop in sessions and also virtually to allow staff an opportunity to ask any questions that they have.

2.3 Application for Injunction Update

The CEO would like to start this update by emphasising that the Trust respects everyone's right to peaceful protest. Unfortunately, in December, a number of

individuals undertook direct action against the December phase of ground investigations works for the new Velindre Cancer Centre which impacted our ability to deliver the works.

On the basis of legal advice, last week the Trust filed a claim for an injunction and in an initial hearing permission was obtained from the High Court to serve our claim. The interim hearing of our application for an interim injunction is being held on the day of the Board and you can find full details of the claim on the Trust website. We will update the Trust Board and also update publicly (including all of key stakeholders) on the next steps following the interim injunction hearing today.

This is not a step that has been taken lightly but it is one we feel we must take for several reasons. We must ensure the safety of everyone working on the site, and those who continue to use public areas of the site as a local amenity. It is also important that the project remains on track to the timescales we have publicly committed, as understood by our patients, staff and the wider public so that we can continue to play our part in improving the outcomes for our cancer patients across south east Wales.

2.5 Scaling up Innovation and Transformation Award

Velindre Cancer Centre and All Wales Medical Genetics Service's pharmacogenetics test has won the prestigious Scaling up Innovation and Transformation Award. The innovative new test can reduce adverse reactions to chemotherapy medications by screening patients in advance of treatment to identify those at risk of severe side effects, using genetic variants to predict the likelihood that a particular drug may cause unintended harm through an adverse reaction.

A pilot began in January 2020 to develop the test and testing pathway for patients due to receive fluoropyrimidine (chemotherapy), along with clinical guideline documents and education packages. To-date, more than 2000 patients have been screened and a total of 225 patients in Wales have had their chemotherapy treatment stratified, therefore reducing their risk of an adverse reaction. The Board has received updates on this groundbreaking work in the latest Velindre Cancer Centre

showcase and the CEO is delighted to be able to share the news of this excellent achievement in winning this award.

2.6 Integrated Medium Term Plan (IMTP) 2022 - 2025

The Trust is developing its IMTP in accordance with the guidance issued by the Welsh Government (WG) towards the end of 2021. Since the Pandemic in March 2020, the 3 year IMTP process was paused with NHS organizations being required to submit quarterly and annual plans, recognising the fast moving nature of the pandemic.

The WG required submission of the IMTP 2022-2025 by February 2022. However, the Omicron variant resulted in the submission date being pushed back to March 31st 2022 to allow further understanding of the pandemic and what it means for future plans. The WG also issued further guidance in January 2022 to be included within the planning process relating to policy priorities and measures to be tracked.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Board is asked to **NOTE** the content of this update report from the Chief Executive.

TRUST BOARD

QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	27th January 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Officer
PRESENTED BY	Vicky Morris, Chair of the Quality, Safety & Performance Committee
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

REPORT PURPOSE	FOR NOTING

ACRONYMS	
PADR	Performance Appraisal & Development Review
SACT	Systemic Anti-Cancer Therapy
COSC	Clinical Oncology Sub-Committee
SCAG	Strategic Clinical Advisory Group
NHSBT	NHS Blood & Transplant
SAE	Serious Adverse Events
HTA	Human Tissues Authority
FTE	Full Time Equivalent

DNA	Did Not Attend

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Quality, Safety & Performance Committee at its meeting held on the 20th January 2022.

The Board is requested to **NOTE** the contents of the report and actions being taken.

2. BACKGROUND

The Quality, Safety and Performance Committee meets on a bi-monthly basis and provides an opportunity to triangulate information and data in respect of quality, safety, finance, workforce, performance and digital. The Committee is continuing to mature, actively seek opportunities for improvement in parallel with the ongoing development of reporting formats and additional assurance mechanisms as it enters its second year of operation.

3. HIGHLIGHT REPORT

The agenda for the Committee had been amended to take account of the current pressures being faced by the Trust due to the fourth wave of the pandemic that commenced in December 2021. This resulted in enhanced COVID and Divisional reporting and a deferral of some items on the cycle of business. The Committee was assured that all deferred items will be received by the March 2022 meeting. Since December 2021 the Trust had re-commenced its command management infrastructure that included Gold and Silver Commands.

The Committee was **ASSURED** by evidence of an improving position over the past two weeks in respect of the fourth wave of the COVID pandemic. This was evident in both national figures and the impact on the Trust. Throughout this wave, the core services and treatments delivered by both Divisions has continued despite the impact of COVID related staff absenteeism, overall sickness levels, social distancing requirements and increasing demand. These issues continue to be proactively mitigated via additional staffing allocation / deployment as part of the current recovery plan.

The Committee **NOTED** that the learning applied from the previous waves of the COVID pandemic have enabled the Trust to continue to evolve and adapt its systems and processes, strengthening its overall position.

The following areas were highlighted for reporting to the Trust Board from the Public meeting of the Quality, Safety & Performance Committee held on the 20th January.

ALERT / ESCALATE	**Gold Command Highlight Report** The Gold Command Highlight Report provided an overview of the functioning of the Gold Command meetings held between 15th December 2021 and 13th January 2022. The areas within this report for alerting to the Committee were: • ***Systemic Anti-Cancer Therapy (SACT):*** The deteriorating position in relation to SACT provision during January 2022. In December there were 6 new patients who waited more than 21 days for commencement of treatment (all treated very soon after the 21 days). In January 2022, despite all endeavours (including additional clinics) this is anticipated to be far greater (27 patients waited longer than 21 days by 13th January 2022). This was predominantly due to the level of staff absenteeism in January 2022 as well as level of demand. Gold Command received three times a week updates in respect of the SACT delivery position and was advised of the range of mitigating and risk reduction measures put in place. This included clinical prioritisation to ensure any patients waiting longer than 21 days were no / low risk, no / low risk therapy changes made (conversion to oral or injection rather than infusions) and additional capacity arrangements being put in place with the Rutherford Cancer Centre. The Committee was ASSURED that patients were receiving SACT in clinically prioritised order and all time critical treatment was being delivered in line with required timescales as long as patients have been well enough to receive it. The Committee was **ASSURED** that a formal impact assessment in relation to the commencement of clinical prioritisation had been undertaken prior to any changes taking place. The Committee also **NOTED** that a review of the support arrangements in place for staff to ensure proactive management of

	waiting times has been initiated following the receipt of two informal complaints from patients. • ***Radiotherapy performance:*** Some pressure had been experienced within Radiotherapy Services due to staff absenteeism and increasing demand. A risk based approach had been taken to manage this and some no / low risk based changes made to prostate radiotherapy. The situation has since recovered and usual treatment regimes for prostate patients has recommenced. Radical and emergency Radiotherapy have shown a decrease on recent performance at 78% and 89% respectively, while palliative radiotherapy remains stable at 84%. The Committee was **ASSURED** that a formal impact assessment had been undertaken prior to these changes taking place. Following detailed discussion at the November Committee in relation to Radiotherapy performance, the deep dive exercise within Radiation Services planned for Board Briefing in January 2022 had not been completed due to the current Omicron wave and will be included in a future Board development day.
ADVISE	**COVID Update** All Trust Board members were invited to receive a COVID update presentation at the outset of the meeting. This replaced the Board Briefing session previously scheduled for the 13th January 2022. Overall staff across the Trust were commended for maintaining critical services throughout this wave. The following highlights were provided: ***National picture:*** • Marked reduction in the incidence of COVID cases per 100,000 as January 2022 is progressing, with most recent reports indicating 529 per 100,000 in comparison to 2,228 at the beginning of January 2022. • Evidence of a decrease in the number of positive tests, indicating a potential move from 'pandemic' to 'endemic'. • Evidence of a reduction in staff absence across Wales. ***Trust position:*** • Gold and Silver structure has been maintained with a move in

recent days to recovery planning.

- Core service / treatment delivery has been maintained over Christmas and during January 2022, assisted by overwhelming support, commitment and dedication from staff across all services.
- In the last week service pressures are easing due to reduced staff absences.
- Continued application of Welsh Government COVID guidance, facilitated via robust communications and site management; working from home position has been maintained with the closure of Trust Headquarters during January 2022.

Velindre Cancer Service:

- Service delivery has been maintained, with continued SACT delivery supported by deployment of staff from wards and non-patient facing roles. Outreach provision has been maintained and outpatients has seen an increase in virtual appointments.
- Radiotherapy has continued with a 25% reduction in capacity due to fleet issues, reduced workforce and COVID restrictions.
- Inpatient bed numbers continue to be maintained and visiting permitted on a case by case basis.
- Availability of patient information videos and support.
- Continued improvement in staff absence.
- Close monitoring of capacity and demand planning via regular meetings with Health Board teams.

Welsh Blood Service (WBS):

- The Blue alert issued in December 2021 due to a reduction in stock levels was lifted on 18th January 2022. The WBS continued to provide all required blood and blood products and did not need to import.
- Evidence of a reduction in donor 'Did Not Attend' (DNA) rates in recent weeks.
- Stock position currently healthy (including red cells and platelets) and continued engagement with UK blood services to ensure adequate supply across the UK blood chain.
- Promotion of support for the WBS been enhanced via TV and radio exposure.
- Gradual improvement in staff absences.
- Risk and impact assessment of social distancing reductions undertaken will enable enhancement of capacity and focus will now be on where and when clinics will be feasible in line with donation planning.

COVID Risks:
The risks associated with the prevalence of the Omicron variant have changed rapidly as this wave has progressed. Five risks identified, four of which have been decreasing (overall COVID risk: 12; impact of working from home on wellbeing of staff: 8; WBS stock levels: 12; staff absenteeism affecting ability to deliver SACT 16; Radiotherapy: 16). The risk that remains unchanged in recent weeks is isolation regulations impacting on patients being able to commence treatment: remains a 16.

Additional Interventions monitored via the Health and Wellbeing Steering Group:
Assurance was received that the wellbeing of staff is considered during the decision making process with the implementation of a number of wellbeing interventions, regularly communicated to staff and managers alike. This included the implementation of Mental Health first aiders.

Quality & Safety Reporting

COSC targets:
It was advised that additional funding will be required if COSC (Clinical Oncology Sub-Committee) stretch targets are to be met, presenting additional cost pressures. Further work to quantify this is being undertaken and an update will follow.

Velindre Cancer Service – Patient Story

The Committee received a powerpoint patient story that had been shared with Velindre Cancer Centre by the family of a deceased patient during a meeting with clinical teams. The story featured the experience of the patient and his family whilst having to attend clinical appointments alone due to COVID restrictions. This resulted in the patient's wife not being fully informed of the extent of his cancer and her being unable to support him making informed choices regarding his treatment.

It was recognised that this occurred at the beginning of the pandemic, during a time of rapid and constant changes to guidelines, ways of working and compounded by staffing challenges and mainly virtual communication within the Palliative Care provider for the patient. Significant changes have since been made in relation to how families are involved in difficult conversations.

	The meeting held between the patient's wife, Oncology and Palliative Care staff provided an opportunity for her for the first time to have a discussion to understand the disease he had and the events that took place. It was recognised at the meeting that there were a number of areas that could be improved as a result of the feedback, some changes had already been made as we have progressed through the different waves of the pandemic. The Committee was **ASSURED** that a number of changes to processes have been implemented during the course of the pandemic, such as the introduction of a heated outdoor waiting area and carers' passports to allow patients to be accompanied to appointments. Measures to reduce waiting times in general are also currently being explored.
ASSURE	**Gold Command Highlight Report** In addition to the areas outlined in the alert and advice sections the following was highlighted from the Gold Command Highlight Report: • There had been no incidences of Nosocomial Transmission of COVID during the current wave. • Strategic Clinical Advisory and Clinical Decision (VCC operational) Groups have been established to ensure clinical oversight, decision making and recommendation lines into both the silver and gold command structures. • A revised Decision Making Framework to support decision making through the incident management structure has been approved. **NHS Wales Shared Services CIVAS@IP5 Report** The NHS Wales Shared Services CIVAS@IP5 Quality & Safety Governance Report and performance presentation was discussed. The Committee: • Received an overview of performance against agreed metrics. • Received **ASSURANCE** that there had been no errors and critical process deviations in manufacturing processes identified over the last 9 months. • All facilities and equipment adhere to regulatory standards with the exception of one minor incident which has since been resolved. • Service is 100% compliant with internal audit requirements.

- 3 service complaints were received in the last 9 months, mainly focused on logistical issues in relation to the vaccination programme.
- Was advised of a reduction in documentation review a result of a large volume of documentation due for review at the same time. The Committee was **ASSURED** that a documentation plan to stagger the review of documents was in place and no issues were anticipated in achieving this.

Velindre Cancer Service Quality, Safety, Performance & COVID Report

The comprehensive Velindre Cancer Service report provided an update on performance against key metrics for the period until the end of November 2021. The following was highlighted:

- The last 2-3 months have focussed on providing patient care.
- No further development in relation to reporting structure around the new format (6 domains of quality) due to the current circumstances resulting from the pandemic; this however remains a priority for the Quality & Safety Team and it was acknowledged that this is a work in progress.
- The Committee was **ASSURED** that good progress has been made in relation to the management of complaints and concerns and systems and processes have been implemented to ensure targets are met in terms of putting things right.
- The focus will be triangulation of information, to include waiting times, patient experience, etc.
- Services continue to be delivered safely, evidenced by positive examples of patient experience feedback.

The Committee was **ASSURED** that a work plan is in place to facilitate progression of other areas of work still required.

15 Step Challenge Report – SACT Outreach

The Committee received the summary report from the 15 Step Challenge visit undertaken by an Independent Member and Executive Director within the Velindre SACT Outreach Unit at Prince Charles Hospital on 7th December 2021. The review was extremely positive with exemplar feedback from patients.

A small number of recommendations were made, including a review of

catering arrangements with the hospital to ensure availability of refreshments and snacks for patients during their visit and improved signposting of the unit as a Velindre service. The Committee was advised that the actions arising from these recommendations will be included in the next formal VCC Committee report.

Welsh Blood Service Quality, Safety, Performance & COVID Report

The Welsh Blood Service report provided an update on performance against key metrics for the period until the end of December 2021 and the following items were highlighted:

- Ability to deploy staff in challenging circumstances to enable robust and safe delivery of services throughout this period.
- Blue Alert has been lifted.
- The Welsh Blood Service remains the only service outside NHSBT (NHS Blood & Transplant) that has not 'imported' during the period.
- Wide media coverage this week will be supplemented by the Health Minister who will attend WBS as a donor.
- Stem cell activity has continued as planned with no disruptions to the service.
- Satisfaction scores remain high despite the current challenges.
- An update will be provided on the 15 Step Challenge recommendations at the next formal Committee, potentially in the form of a donor story in relation to special needs services.
- Having previously been an undisclosed site for the storing and distribution of COVID-19 vaccines or the NHS Wales vaccination programme, this information is now permitted in the public domain. Over a **million vaccines** have been handled / distributed out of WBS in December alone.
- Confirmation of agreement from Betsi Cadwaladr to join the immunoglobulin supply.
- An increase in the reporting of incidents is a result of the unprecedented workload of the team. Internal redeployment of staff and a level of external support has resolved a number of issues.
- Planned audit activity is continuing.
- Two Serious Adverse Events (SAEs) had been reported to the HTA (Human Tissues Authority) during November 2021. Both events were related to stem cell collection and investigations had identified the cause and corrective actions have been undertaken and completed.

The Committee **NOTED** the report and commended the wholescale effort of the team at all levels to deliver the vaccine, address blue alert, and continue to meet supply and demand.

Workforce and Organisational Development Performance Report

The Workforce and Organisational Development Performance Report was received and discussed. The following was **NOTED** for the period ending December 2021:

- Organisational headcount at December is 1,885, equivalent to 1,418 Full Time Equivalent (FTE).
- Overall Performance Appraisal & Development Review rates to December stand at 70.83%.
- The sickness rate absence of 5.54% remains higher than pre-COVID but has remained steady for a number of months, with smaller teams and specific areas experiencing the most significant issues.
- Statutory Mandatory Training compliance stands at 86.4% at the end of December. It is anticipated this will improve following the COVID response timescale.
- Turnover for 2021 stood at 12.75%, the majority of which resulted from promotion or retirement. There is a degree of internal turnover as a result of staff undertaking new roles.
- 357 vacancies were advertised during 2021 and an increase of 3% has been evidenced within Nursing.

The Committee was **ASSURED** that a follow up report would include timescales in relation to job planning, in addition to more accurate representation of information.

The Committee was also **ASSURED** that regular contact / discussions are maintained with staff on long term sickness absence by Managers and the wider Workforce team. It is also clearly stipulated in the policy that staff are not permitted to engage in other employment while absent due to sickness.

Vaccination Programme Board Report

The Vaccination Programme Board Report provided an update in relation to the Trust's COVID-19 booster and Influenza vaccination progress and the following was highlighted:

	• To date, 83% of staff have received a COVID-19 booster vaccination. The small number of staff still to receive vaccinations were transferred to their Health Boards and will receive the booster via this route. • A number of staff had been deployed to assist the vaccination programme within other Health Boards, while others had joined banks. • To date 71% of staff have received their influenza vaccination at the Trust. **Financial Report** The Trust Financial Report, outlining the financial position and performance for the period to the end of November 2021 was discussed. The Committee received **ASSURANCE** that there are no major variances on revenue and capital budget and that formal confirmation had been received that all COVID-19 related funding requirements would be received from Welsh Government. The Committee was also **ASSURED** that the year end forecast is currently expected to achieve a breakeven position. **Trust Risk Report** The Committee discussed and reviewed the Trust Risk Report, summarising the status of all risks scoring 12 or greater and those included with a risk impact of 5. The Committee was **ASSURED** that risk reporting was continuing to mature and develop to provide full transparency and sufficient detail for **ASSURANCE** to the Committee. Further details will be included in the next iteration of the Trust Risk Report to provide the Committee with additional details to demonstrate ongoing management of risks presenting as overdue for review.
INFORM	There were no items identified to inform the Board.
APPENDICES	N/A.

4. RECOMMENDATION

The Trust Board is asked to **NOTE** the key deliberations and highlights from the Quality, Safety & Performance Committee held on the 20th January 2022.

Trust Board Meeting

COVID -19 Update

27th Jan 2022

National Picture

- Incidence of COVID per 100,00 over the last 7 days 529 which is over 1000 lower than last week and compares to 2228 reported 7 Jan.
- Moving to endemic from pandemic.
- Positivity of testing, 35.3% compared to 51.5% reported 7th January.
- Still experiencing rise in inpatients – lag on incidence.
- Services highly pressured across Wales but starting to experience a reduction in staff absences.

COVID UPDATE

- Maintaining Gold/Silver command structure – starting to move to recovery planning.
- Engaged with the multi-agency South Wales Local Resilience Forum – reflecting similar experience in other public sector organisations.
- Maintained service delivery across the holiday period and into January with positive benchmarking against other blood and cancer services.
- Recognition of the overwhelming support and some workforce pressure lifting with reduction in staff absences.
- Frameworks - Clinical Principles, Radiotherapy and SACT, Patient Testing.
- IPC & Microbiology real time oversight of changing guidance – rapid comms when needed.
- Covid cell - application of Covid guidance from WG, site management and workforce wellbeing – focus on support for staff.
- Maintained our position of working from home & closed HQ.

VCC

Service delivery

- **Business continuity** plans enacted based on learning each wave.
- **SACT** – all continued with support from RD&I and redeployment of staff from wards and non patient facing roles. Maintaining service against increased demand with breaches in January 2022 for category 5 and 6 patients only, based on the agreed clinical prioritisation criteria (no/ v low clinical impact)
  - Maximisation of Oral SACT and Sub Cut injection provision, now running at 32% and 21% above pre-covid levels respectively.
  - Third party provision discussion underway.
- **All AU** and Ambulatory care being maintained.
- **Increased OP** virtual appointments.
- **Outreach** provision maintained.

- **RT –** maintained 25% reduction in capacity, major limitations on fleet and reduction in workforce but maintaining service with increase in breaches with prioritisation based on clinical need.
  - Maximising third party provision - 26 patients treated at RCC during December.
- **Inpatient** – maintaining bed numbers and visiting at discretion of staff based on situation.

VCC

Clinical Frameworks – National Guidance COSC

- RT – Prostate changes – A small cohort of prostate cancer patients receiving neo-adjuvant hormone treatment.
- RT – Skin - Basal Cell Carcinomas of the skin has been temporarily deferred.
- Raises in neo-adjuvant referrals (Breast C&V).

Patient Information and support

- Information videos.
- Key messages for one to one discussions.

Staff absence – improving position

- SACT – reduced from 14%, by 1-2%.
- RT - 14% Covid Related Absence, 8% other absences, including mat leave.
- SACT staffing - realignment from wards, senior staff deployed, RD&I capacity utilised to full.
- Med Physics 4%, Radiology 11%, Medical staff 4%.
- HCSW 27%.

Capacity and demand planning

- Demand analysis utilising health board cancer tracker data identified patient delays in reaching VCC in December. Data has shown that the patients are in the system and will present to us at later stages of the pathway.
- Formal operational meetings with Health Board teams to share organisational pressures and challenges and support optimal patient pathway delivery.

December performance

- Dec figures SACT 21 day target
  - Emergency 100%
  - Non Emergency 99%

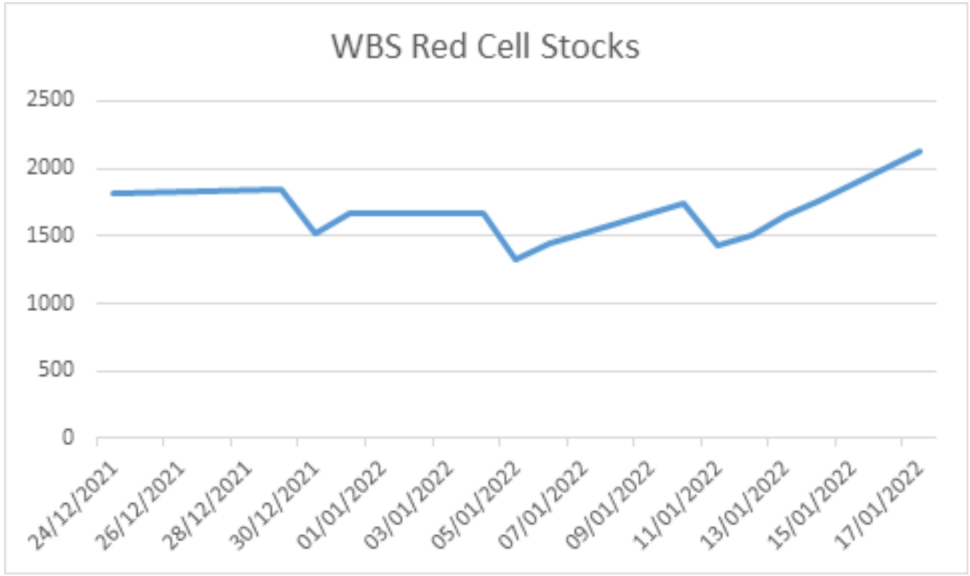
Dec 2021 SACT waiting time data		
Waiting time	Patients	%
0-7 days	148	40.5%
8-14 days	49	13.%
15-21 days	162	44.4%
22 – 28 days	5	1.4%
29 days	1	0.3%
Total	365	

The **invalidated** SACT performance position as of 13th January 2022 is that a potential total of 27 patients have waited more than 21 days to initiate SACT (6 in Dec). This will decrease on validation.

- Radiotherapy
  - Radical 78% - decrease on recent performance
  - Palliative 84% - maintains recent performance
  - Emergency 89% - decrease on recent performance

WBS

- Stock position including red cells and platelets have recovered over last 10 days supported by extra weekend clinics.
- Improved DNA rates on donor attendances achieved.
- TV and radio exposure English and Welsh promoting the need to support service over coming weeks during the winter to be aired.
- Reinforcing criticality of Donors attending session via digital media channels and texts.
- Continued active engagement with UK blood services – All appears to be rebounding and improving stock position.



WBS

- Blue alert lifted on Jan 18th 2022.
- Blood banks continue to work closely with service.
- Staff absences also improving slowly particularly in supply chain operation.

- Risk Assessment and impact assessment of social distancing reductions supported at Gold working within WG guidance
  - Reduction enabled in WG guidance.
  - Capacity enhancement.
  - Complex venue / geography relationship – recovery planning focus - where and when we take clinics and how this aligns with the donation planning.

Covid Risks

5 Risks opened and assessed

- Safety – Corporate and VCC
- Workforce and OD – Corporate
- Performance and sustainability – for WBS and VCC

- The risk profile - Quality, Safety and Performance Committee on 17th, and Trust Board on 27th January.

Additional Interventions – Monitored via the Health and Wellbeing Steering Group

- MH First Aiders
- Leadership and Management Development focus on wellbeing
- Work in Confidence platform
- REACTMH
- Network developments
- H&WB Champions and Network
- Mediation Network
- Healthier Working Relationships and policy development / guidance – focus on Respect and Resolution
- Wellness Action Plans in Divisions
- Learn from colleagues feedback / ongoing surveys / engagement sessions

TRUST BOARD

NOVEMBER PMF COVER PAPER

DATE OF MEETING	27/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Anna-Marie Jones, Business Support Manager Wayne Jenkins, Head of Planning and Performance Alan Prosser, Director WBS
PRESENTED BY	Cath O'Brien, Interim Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Interim Chief Operating Officer

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
QS&P	20.01.22	Noted
EMB RUN	4.01.2022	Reviewed and Noted
WBS SMT MEETING	17.12.21	Reviewed and Noted
VCC SLT MEETING	20.12.21	Reviewed and Noted

ACRONYMS	
VUNHST	Velindre University NHS Trust
UHB	University Health Board
VCC SLT	Velindre Cancer Centre Senior Leadership Team
WBS SMT	Welsh Blood Service Senior Management Team
RCR	Royal College of Radiologists
JCCO	Joint Council for Clinical Oncology
PADR	Performance Appraisal and Development Review
KPIs	Key Performance Indicators
SACT	Systemic Anti-Cancer Therapy
WTE	Whole Time Equivalent (staff)
EMB	Executive Management Board
COSC	Clinical Oncology Sub-Committee
SPC	Statistical Process Control

1. SITUATION/BACKGROUND

1.1 The attached Trust performance reports provide an update to the Executive Management Board (EMB) with respect to Trust-wide performance against key performance metrics through to the end of November 2021 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The reports set-out performance at Velindre Cancer Centre **(*appendix 1*),** the Welsh Blood Service **(*appendix 2*)** and Corporate Workforce report (**appendix 3**) Each report is

prefaced by an '*at a glance*' section which is intended to draw attention to key areas of performance. A number of areas from the reports are highlighted below.

2.2 Velindre Cancer Centre:

Covid continues to impact our service planning and delivery. Covid related absences, capacity reductions due to IPC measures and increasing patient numbers are all having an impact on our service provision and waiting times. Whilst we are still providing excellent care for our patients it is against a significant backdrop of restrictions and challenges.

Despite the challenging environment, only 2 targets were reporting red in November's performance report. These were the palliative radiotherapy within 14 days target and the outpatient 30 minute wait target. In addition the new measure which we are also reporting on for Radiotherapy (COSC) are red and not achieved as we continue to work towards these.

Since April 2021, we have been mandated by the Welsh Government to report against the COSC targets. These targets align more closely with the direction of travel for reporting against the Single Cancer Pathway.

The COSC targets present different criteria and different time points of reporting (Scheduled, Urgent and Emergency- within 1 day). Work is underway to ensure that we can accurately manage patients and report against these newly adopted COSC measures and to ensure our patient pathways are redesigned in order to meet the new criteria definitions.

The challenge in meeting the revised COSC targets may require significant investment from our commissioners, to enable us to implement the changes required over and above patient pathway efficiency improvements that are already being worked through.

Radiotherapy Waiting Times

Radiotherapy services are under pressure as a result of referrals returning closer to Pre Pandemic levels after a year of reduced referrals. In addition, IPC restrictions continue to reduce treatment capacity by circa 25%. Performance against waiting times targets is worsening and we expect to report more breaches in the coming months as a result of both above. We continue to explore all options for increasing capacity as well as making the best use of existing capacity. This includes further exploring third party provision.

The total number of referrals received in November 2021 (404) represented a marked increase relative to the previous month (351). The number of new referrals in November also far exceeded the average number received in any given month in 2020/21 (315).

Patient delays are reflective of challenges in the capacity for both Brachytherapy and 3D conformal planning and late changes to clinical management intent as a result of changes in patient need. Where there is a change in treatment intent, due to systems the patient is still measured against their original treatment intent and so anomalies are created in the measurements. Future system changes will address this. This is further outlined later in this paper.

There are a number of areas of focus for the Radiotherapy team in addressing the challenges above:

Brachytherapy demand currently exceeds capacity. We are peer reviewing our brachytherapy provision with Clatterbridge cancer centre who have a similar demand profile to ourselves and who have been through a similar process for implementing Brachytherapy. This includes reviewing protocols, standard operating procedures, staffing profiles etc. This will enable us to optimise our pathways and build in the true capacity requirements for the service. The Brachytherapy project board is working with WHSSC to resource the service requirements, while assuring ourselves and commissioners that we have undertaken Peer review to support our future plans.

The growth in the use of 3D Planning continues and the corresponding increase in the medical physics workforce to undertake the work is being addressed but is problematic. We are addressing the requirements within physics by reviewing options including training more existing staff and attracting new staff with these skills.

Increasing workload for medical staff is resulting in some late submission of plans and work is not evenly distributed through the week. Remodelling is underway and it is recognised that there is a pathway wide impact on workforce planning that is complex to remodel. This work is underway with the medical directorate but will not be an immediate solution.

Late changes in patient treatment category, primarily from palliative to emergency results in patients regularly treated outside of the emergency treatment time. Effectively a late change means that the patient will already have exceeded the wait for emergency treatment at the date of change of intent, due to the time the patient has already waited. We are reviewing whether the correct system actions are being taken when making such changes as well as working with the clinical teams to understand why these late changes are occurring frequently.

The forward look for radiotherapy is showing reduced performance for December and January due to increasing numbers of referrals and staffing challenges due to Covid sickness/isolating, and other absences/vacancies. We are working with the Rutherford Cancer Centre to maximize use of their capacity for Breast and Prostate patients.

The management of the patients being referred for Radiotherapy is being undertaken in line with the agreed Clinical Frameworks which includes clinical risk based prioritisation. For example, some patients are able to be managed on alternative treatments while awaiting their radiotherapy.

SACT Waiting Times

The waiting times target for non-emergency SACT was met. This has been achieved in the most difficult circumstances and is becoming difficult to sustain. This performance has been achieved by the hard work of the staff by improving the booking processes, increasing the utilisation of chair capacity and an additional day on the Tenovus mobile unit.

7 patients referred for emergency SACT treatment were scheduled to begin treatment in November 2021. 2 patients did not begin treatment within the target time. These patients began treatment on day 6 and day 7 with the agreement of treating clinicians.

There is a challenging picture ahead for SACT provision. Unexpected staff shortages due to Covid/isolating and other sickness are ongoing and alongside growing referrals has resulted in us revisiting clinical priority and SACT escalation procedures. We are experiencing a decrease in performance over December and January. We continue to identify opportunities for additional capacity from third party supplies. Patient clinical prioritisation is being undertaken through the agreed clinical frameworks.

Outpatient waiting times

This target is reporting as red as we are not hitting the 30 minute target. The longest patient wait (148 minutes) and that was due to a complex patient pathway requiring appointment time with Clinical Nurse Specialist, non-medical prescriber and Consultant. The plan is to split the targets into waits from first arriving in the department both to consultant outpatient attendance and to phlebotomy separately and then the wait from phlebotomy reporting to seeing the consultant. Due to staff absences this data was not available for November. Future data will enable reporting of:

- Time to consultant only appointment.
- Time to blood test.

This will then enable us to report waiting for a consultant appointment and waiting time for phlebotomy.

We are currently working through various plans to improve the waiting time. Capital funding has been secured to undertake environmental improvement work in the department. We are looking at a number of options identified by an external consultant to release capacity and aid patient flow and will produce a Business case in February 2022 with our preferred options. Work is also being undertaken to map patient flow which will form the basis of an improvement project (January 2022).

Therapies

All Therapy waiting times targets were reporting green.

Other areas

Falls –

During November 2021 there 1 fall was reported on first floor ward, a full investigation was undertaken by the VCC Falls Scrutiny Panel. Following investigation, the fall was deemed to have been unavoidable.

The patient had been the subject of a falls risk assessment on admission, but mobilised without staff assistance and fell.

Following the incident the falls pathway was completed and the patient reviewed by a medic. The patient experienced no harm.

Pressure Ulcers – There were no pressure ulcers reported.

Healthcare Acquired Infections – No healthcare acquired infections were reported.

SEPSIS bundle NEWS score

Twelve patients met the criteria for administration of the sepsis treatment bundle in November 2021. All twelve received all elements of the bundle within one hour. Five of the patients subsequently received a diagnosis of sepsis or neutropenic sepsis.

Delayed Transfers of Care (DTOC's)

During November there were no DTOC's.

Further detailed performance data is provided in Appendix 1

2.3 Welsh Blood Service

November's PMF again represents a strong performance by the service. There has been a further improvement in quality incidents closed in 30 days, improvement in our platelet expiry rates and an improvement in our donor experience rates.

Blood stocks in November within Wales are reported as being stable and held up well, in what are proving to be challenging times for UK blood services.

However, the service is continuing to experience high staff absences throughout the blood supply chain operation within both collection teams and laboratory staff across all grades due to a range of issues including Covid, long and short term sickness.

In addition, blood collection continues to be a challenge with social distancing measures, and collection venue constraints. The effort of the planning, engagement and contact centre team staff continues to be exemplary during this period in ensuring capacity is maximized and alternative venues can be sort at short notice.

WBS Christmas campaign launched at the end of November and was promoted across a number of media and digital channels to help maintain supply.

All demand for red cells were met in November and all stock groups continued to be maintained above 3 days with an average of 1409 units issued per week. All clinical demand for platelets was met as well averaging 199 units per week for November.

There were 6 Stem Cell Collections in November. 5 by the Peripheral Blood Stem Cells (PBSC) collection method and 1 by bone marrow harvest.

The VCC apheresis stem cell collection service previously supported through St Joseph's, had its first collection on Monday 8th November.

At the time of writing this report (December 22nd) the service has raised a BLUE alert to blood banks and Health Boards across Wales (December 16th) indicating specific pressure on supply of group O positive red cells is challenging and that pressure on additional blood groups is likely to increase for a sustained period given the onset of the Omicron variant. A number of contingencies were put in place and reported via the divisional silver command group to the Trust Gold group.

In preparing this report post the holiday period, it is of note that the implementation of the BLUE alert enabled stocks to be successfully managed in close collaboration with HBs over the holiday period despite challenges in collections.

2.3.1 Recruitment of new bone marrow volunteers

The inability to hold whole blood donation clinics in schools and Universities, continues to hinder recruitment of new bone marrow donors. The number of new volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 210 for November. Work is underway to promote the newly introduced buccal swab administration with donors to improve the performance going forwards.

2.3.2 Reference Serology

There were 255 hospital patient referrals in November 2021 compared to average of 181 in 2020. The increase in referrals has resulted in the target for turnaround times not being met. Work continues to be prioritised based on clinical need and all compatibility testing was completed in the required deadline. It should be noted all requests are screened and considered appropriate.

Requests out of hours and on call attendance impacts staff the next day and as a result affects overall performance. WBS are currently reviewing why the numbers of referrals are so high and timings of requests. The results of this audit will be presented and discussed this at the national pathology managers group in early 2022 and an action plan will then be developed.

2.3.2 Quality

Incidents reported to Regulator/Licensing

There were 2 Serious Adverse Events reported to the Human Tissue Authority in November both events related to stem cell collection. The one was a medication error with no donor harm and an action plan in place to address the risk of such an error occurring in future. The second relates to donor feeling unwell post stem cell collection and needing a short hospital admission. The donor has made a full recovery.

Incidents closed within 30 days

The performance against the 'Incidents closed within 30 days' measure has achieved a level that is better than target for November. The revised process for managing low-impact incidents has been in place now for 6 months and new reports are reviewed and risk assessed daily and the majority of incidents are fully closed within a few days of reporting.

Part Bag Rates

At 2.40% for November, the combined 'Part Bag' rate has reduced although remains within the tolerance level. Targeted interventions are in place.

Failed Venepuncture Rates

The Failed Venepuncture (FVP) rate for November has also reduced, increasing to 1.60% and again remains within the tolerance threshold of 2%. Although these are in target, the review process identifies if there are requirements to put targeted interventions in place and this has been identified a number of individual interventions.

Whole Blood Collection Productivity

Whole Blood Collection productivity whilst having improved from the previous month is below target as there is a continuing requirement to deploy additional resources to clinics due to COVID related infection prevention and control activity. Work is also underway in terms of skill mix review and considering staffing resilience requirements for geographically remote teams.

Manufacturing Productivity

The manufacturing performance figure increased in November due to changes in staff levels due to sick and deployment to vaccine distribution. This metric is based on a pre Covid benchmark with other services and the service has identified a number of anomalies in this metric and it is currently being reviewed.

Number of Concerns Received

In November approximately 7,500 donors were registered at donation clinics. A total of 10 concerns (0.13%) were reported, of which 9 were managed within as early resolution with 1 formal concern reported in November which will be managed and completed before the 30 day Putting Things Right (PTR) target.

Donor Satisfaction

In November overall donor satisfaction continued to exceed target at 97.2%. In total there were 819 respondents, who had made a full donation and shared their donation experience.

Further detailed performance data is provided in Appendix 2

3.0 Workforce

PADRs

Workforce team continue to support managers to improve PADR compliance by coaching and developing capabilities as line managers and by demonstrating the motivational and organisational value of goal setting for all staff.

Labs and WTAIL departments achieved over 85% compliance

VCC – 70.12%. Overall compliance down from previous month (73.77%). Workforce Operational Team continue to highlight PADR compliance in regular meetings with managers

Sickness absence

a. WBS - Long-term sickness absence has increased in November to 5.48%, short term sickness absence has increased to 2.90%. Some concerns raised by line managers re: Occupational Health referral times, this has been escalated to Workforce who are currently looking at the SLA with Cardiff and Vale HB and Betsi Cadwalader HB.

b. VCC - Short-term sickness is 2.19% and long-term sickness absence is at 3.60%. Workforce and OD operational team are currently undertaking sickness audits, to understand compliance of the policy and support required by management to progress cases.

3. Stat&Mand compliance

a. WBS remain within compliance at 93.36% and will aim to continue

b. VCC has steady increase in compliance once more this month to 84.91%

4.0 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current performance reporting and monitoring system is predicated upon identifying performance issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Delivery against the performance metrics presented in the attached reports and the work associated with delivering improved performance supports sound financial governance across the Trust.

5.0 RECOMMENDATION

5.1 Trust Board is asked to **NOTE** the contents of the attached performance reports.

Appendices

1. VCC May PMF Report

2. WBS May PMF Report

Velindre Cancer Centre Monthly Performance Report Summary Dashboard (November 2021)

The table below includes two measures for the performance for radiotherapy service provision. The JCCO is the measure that has historically been reported. It defines patients into certain categories as detailed below. The newer COSC measure has been introduced in 2020 and sets a reduction in the days target for treatment commencing that we and other centres are working towards. The measure is based on different categories of patients and new definitions and as a result the two data sets are not directly comparative. We will continue to report both sets of measures to provide the board assurance that we are maintaining service while also providing progress against the new target. The detailed narrative reports against the JCCO target.

			Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page 6) ***(JCCO Measure)***	Actual	92%	95%	97%	92%	89%	95%	94%	97%	96%	97%	96%	92%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Palliative Radiotherapy Within 14-Days (page 8) ***(JCCO Measure)***	Actual	93%	90%	97%	90%	85%	95%	85%	82%	82%	82%	82%	74%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency Radiotherapy Within 2-Days (page 10) ***(JCCO Measure)***	Actual	93%	95%	97%	100%	97%	100%	100%	97%	100%	97%	100%	85%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Scheduled Patients Beginning Radiotherapy Within 21-Days (page 11) ***(COSC Measure)***	Actual					35%	28%	37%	35%	31%	27%	36%	36%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Urgent Scheduled Patients Beginning Radiotherapy Within 7-Days (page 11) ***(COSC Measure)***	Actual					41%	48%	40%	54%	52%	52%	35%	41%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Emergency Patients Beginning Radiotherapy Within 1-Day (page 11) ***(COSC Measure)***	Actual					83%	88%	85%	82%	86%	82%	86%	77%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
SACT	Patients Beginning Non-Emergency SACT Within 21-Days (page 15)	Actual	86%	79%	77%	88%	98%	98%	98%	99%	99%	98%	99%	99%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency SACT Within 2-Days (page 16)	Actual	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Outpatients	New Patient, other Outpatient and Chemotherapy Assessment Appointments Where Patients Were Seen Within 30 minutes of the Scheduled Appointment Times (National Target) (page 20)	Actual	67%	66%	65%	57%	66%	79%	76%	76%	53%	53%	65%	65%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Did Not Attend (DNA) Rates	Actual	2%	3%	2%	3%	3%	4%	4%	5%	5%	5%	5%	5%
		Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Therapies	Therapies Inpatients Seen Within 2 Working Days (page 23)	Actual (Dietetics)	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%

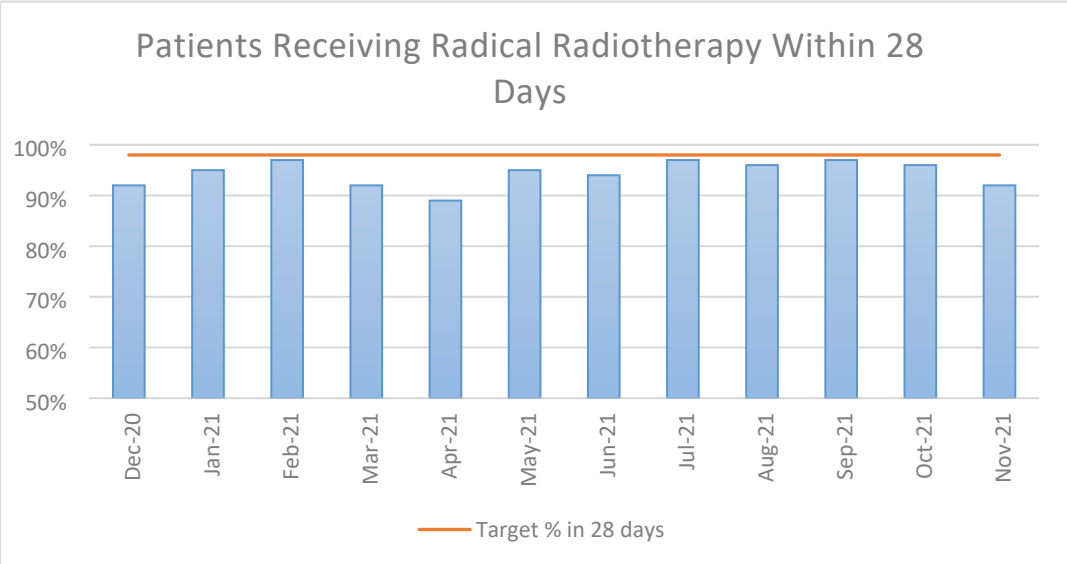
			Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Therapies Outpatient Referrals Seen Within 2 Weeks (page 23)	Actual (Dietetics)	97%	100%	100%	100%	100%	100%	84%	94%	94%	98%	97%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Routine Therapies Outpatients Seen Within 6 Weeks (page 23)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	96%	33%	78%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	96%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Safe and Reliable Care	Number of VCC Acquired, Avoidable Pressure Ulcers (page 25)	Actual	2	0	0	0	1	0	0	0	2	1	1	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Pressure Ulcers Reported to Welsh Government as Serious Incidents	Actual	0	0	0	0	1	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of VCC Inpatient Falls (page 27)	Actual (Total)	2	1	1	1	2	3	1	3	4	2	3	1
		Unavoidable	2	1	1	1	1	3	1	3	4	1	3	1
		Avoidable	0	0	0	0	1	0	0	0	0	1	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Delayed Transfers of Care (DToCs)	Actual	0	0	0	0	0	0	0	0	1	0	4	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Potentially Avoidable Hospital Acquired Thromboses (HAT)	Actual	0	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Patients with a NEWS Score Greater to or Equal to Three Who Receive all 6 Elements in Required Timeframe (page 29)	Actual	100%	100%	100%	100%	100%	100%	100%	80%	100%	75%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
	Healthcare Acquired Infections (page 30)	Actual	0	1 (*C.diff*)	0	0	0	0	0	1 (*C.diff*)	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Episodes Clinically Coded Within 1 Month Post Episode End Date		Actual	99%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
		Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

RAG rating above indicates: Green - Target was achieved. Amber - 85% Compliance or above. Red - Target not achieved.

Patients Receiving Radical Radiotherapy Within 28-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance



The number of patients scheduled to begin radical radiotherapy treatment in November 2021 (186) exceeded the monthly average observed in 2020-21 (150) and was higher than the number scheduled to begin treatment in November 2020 (164).

26 patients referred for radiotherapy treatment with radical intent did not begin treatment within the 28 day target constituting an overall performance rate of 92**%.**

The 26 patients who did not begin treatment within 28 days, commenced their treatment at the following points:

Treatment Intent	≤ 35 days	≤ 45 days	≥ 46 days
Radical (28-day target)	19	4	3

Summary of delays:
A combination of very specific planning clinic requests made by consultants based on patient need. Brachytherapy treatment demand is in excess of our capacity.

Of the patients waiting over 45 Days, Brachytherapy and Urological capacity caused the delay. The demand for brachytherapy is above commissioned capacity which is being addressed with commissioners.

Social distancing and other infection control measures present particular challenges in the delivery of radiotherapy. Capacity has been reduced by 25% due to these COVID precautions.

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (November 2021)
Radical	167	150	186
	Patients Scheduled to Begin Treatment (November 2019)	Patients Scheduled to Begin Treatment (November 2020)	
	171	164	

There is a process for ongoing review of breaches and remedial action where required while longer term service improvements are being delivered as part of Velindre Futures and IRS.

Action:

- A Peer review exercise with Clatterbridge is underway to assess areas for improvement and development for Brachytherapy.(by April 22)
- Brachytherapy expansion business case being written to obtain support for increased capacity with WHSCC.(by April 22)

Wider Actions

There are a number of actions ongoing that are part of wider service change.
Radiotherapy patient pathway project initiated. Project will identify efficiencies for implementation and areas for overall improvement. This will continue to incorporate changes required for IRS through 2022.

- Project initiated to identify process issues and ensure timely delineation of plans (December 2021).

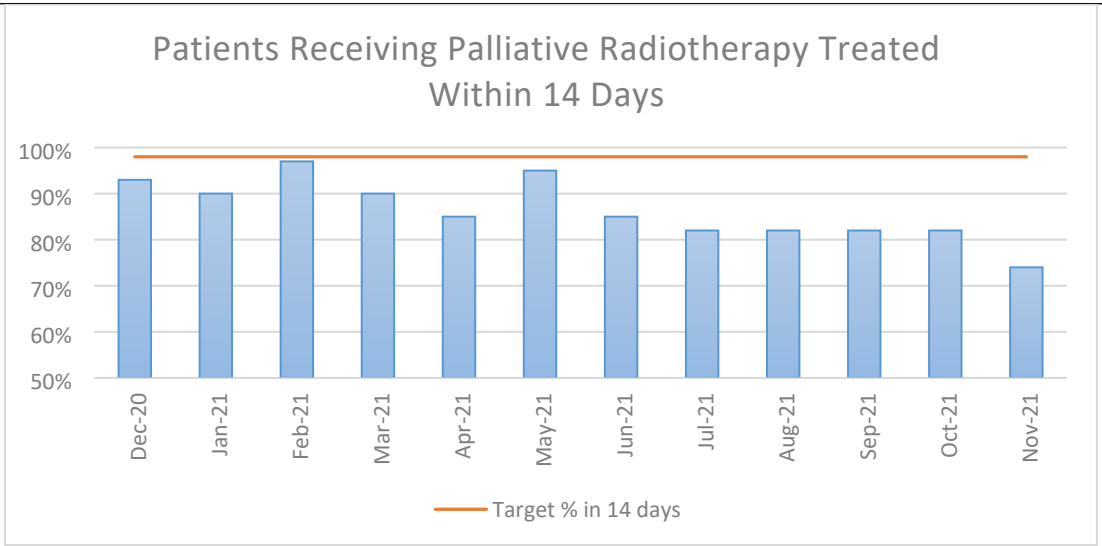
- COSC measure working group – this group is using a pathway approach on a site by site basis

<table>
<tr><td></td><td>to eliminate delays in the process to enable us to meet the new measures. This has been completed for: Head and Neck patients with further work planned for all SST's during 2022.</td></tr>
<tr><td colspan="2">Patients Receiving Palliative Radiotherapy Within 14-Days</td></tr>
<tr><td>Target: 98%</td><td>SLT Lead: Radiotherapy Services Manager</td></tr>
<tr><td>Trend</td><td>Current Performance</td></tr>
<tr><td></td><td>32 patients referred for radiotherapy treatment with palliative intent were scheduled to begin treatment in November. Of this total, 12 patients did not begin treatment within the 14 day target constituting an overall performance rate of 74%.

The 32 patients who did not begin treatment within 14 days, commenced their treatment as follows:

<table>
<tr><th>Treatment Intent</th><th>≤ 20 days</th><th>≤ 25 days</th></tr>
<tr><td>Palliative (14-day target)</td><td>27</td><td>5</td></tr>
</table>

Summary of delays:</td></tr>
</table>



The number of patients scheduled to begin palliative radiotherapy treatment in November 2021 (83) exceeded the monthly average observed in 2020-21 (74) and equalled the number scheduled to begin treatment in November 2020 (73).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (November 2021)
Palliative	82	74	83
	Patients Scheduled to Begin Treatment (November 2019)	Patients Scheduled to Begin Treatment (November 2020)	
	74	73	

- Request for and development of 3D conformal plans (8) due to the clinical benefit of this is the principle reason for treatment delays.

3D plans is an area of growing volume due to the potential for better patient outcomes through normal tissue sparing.
A clinical decision is made with the patient for a more individual complex plan as a result.

Action:

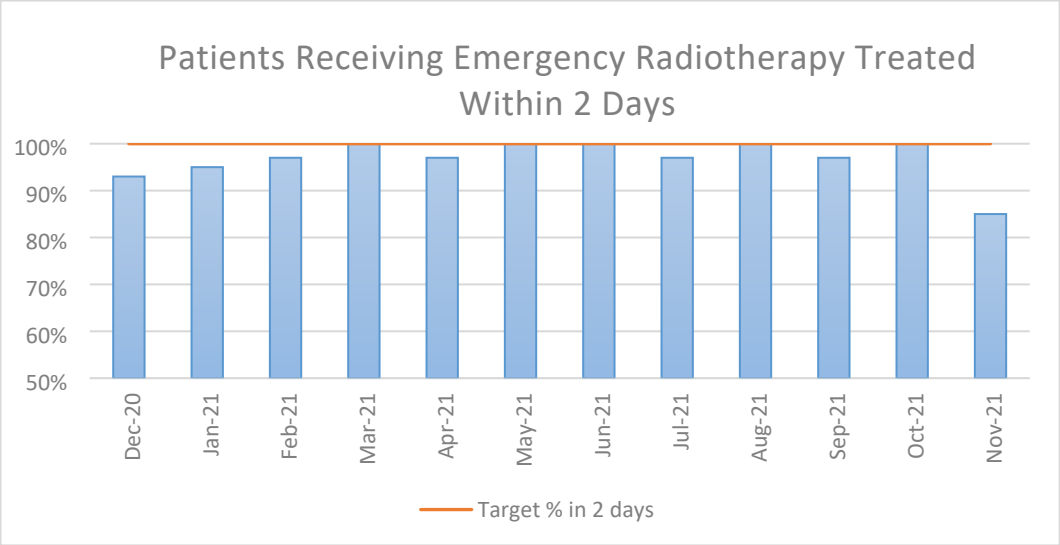
- 3D plan capacity plan to be developed with clinical team as they are the major cause of breaches.

Wider Actions

As above in Radical target actions

Patients Receiving Emergency Radiotherapy Within 2-Days

Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance



The number of patients scheduled to begin emergency radiotherapy treatment in October 2021 (22) was lower than the monthly average observed in 2020-21 (27) and the number scheduled to begin treatment in October 2020 (33).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (November 2021)
Emergency	25	27	22
	Patients Scheduled to Begin Treatment (November 2019)	Patients Scheduled to Begin Treatment (November 2020)	
	21	16	

22 patients referred for emergency radiotherapy treatment were scheduled to begin treatment in November 2021. 3 patients did not begin radiotherapy treatment within 2 days of referral constituting an overall performance of **85%.**

Treatment Intent	≤ Day 5
Emergency (2-day target)	3

Summary of delays:

- Consultant request for specific start date.
- Change of treatment intent from palliative to emergency

Actions

Radiotherapy – Operational Context

Latest Performance Consolidated

Measure		Target	VCC Nov-21	SBUHB Jun-21	BCUHB Jun-21
Radical (28-day target)		98%	**92%**	**70%**	**92%**
Scheduled (21-day target)	COSC	80%	**36%**	**31%**	**53%**
Palliative (14-day target)		98%	**74%**	**87%**	**91%**
Urgent (7-day target)	COSC	80%	**41%**	**45%**	**41%**
Emergency (within 2-days)		100%	**85%**	**100%**	**67%**
Emergency (within 1-day)	COSC	100%	**77%**	**100%**	**100%**

The table shown here sets out the latest available performance of the 3 Wales centres relative to the extant time to radiotherapy targets based on Royal College of Radiologists best practice guidance and the novel Clinical Oncology Sub-Committee (COSC) stretch targets.

The two other centres commenced COSC implementation a year earlier than VCC.

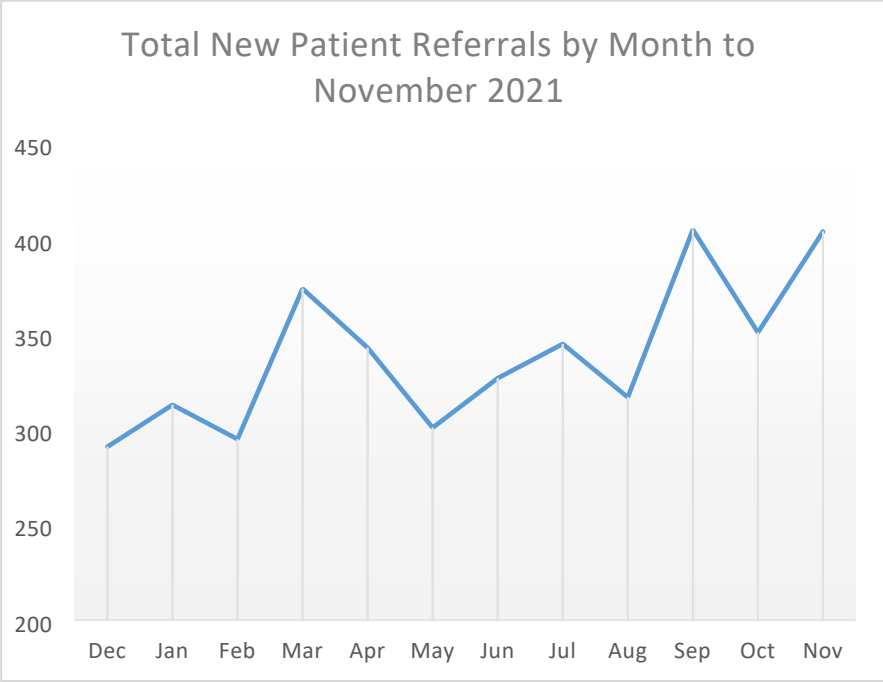
Clinical Oncology Sub-Committee (COSC) Time to Radiotherapy Targets

- Velindre Cancer Centre continues to report good Radiotherapy performance against UK agreed targets as set by the Royal College of Radiologists (RCR), particularly given that we are continuing to deliver services within a COVID driven reduced capacity.
- Since April 2021, we have been mandated by the Welsh Government to also report against the Clinical Oncology Sub Committee (COSC) targets. These targets align more closely with the direction of travel for reporting against the Single Cancer Pathway.
- The COSC targets present different criteria and different time points of reporting (Scheduled, Urgent and Emergency- within 1 day). Our systems are not currently designed to intuitively respond to both the criteria and time points for COSC as the patient pathways and the Radiotherapy planning and scheduling systems, have been designed to respond to the original RCR targets.
- The relatively low performance within Velindre Cancer Centre and the other cancer centres across Wales against the COSC targets currently, does not mean that patients are waiting any longer than they were previously under the RCR targets, only that we have changed the way in which we now categorise patients. We are continuing to report against both measures for comparison at present.
- Work is underway to ensure that we can accurately manage patients and report against these newly adopted COSC measures and to ensure our patient pathways are redesigned in order to meet the new criteria definitions.
- The challenge in meeting the revised COSC targets may require significant investment from our commissioners, to enable us to implement the changes required over and above patient pathway efficiency improvements that are already being worked through.

The table below describes the allocation of individual patients scheduled to begin treatment in terms of the new COSC definitions for November 2021

Scheduled (21 day target)	Urgent (7 day target)	Emergency (within 1 day)
164	73	16

Referral Trends - Overall

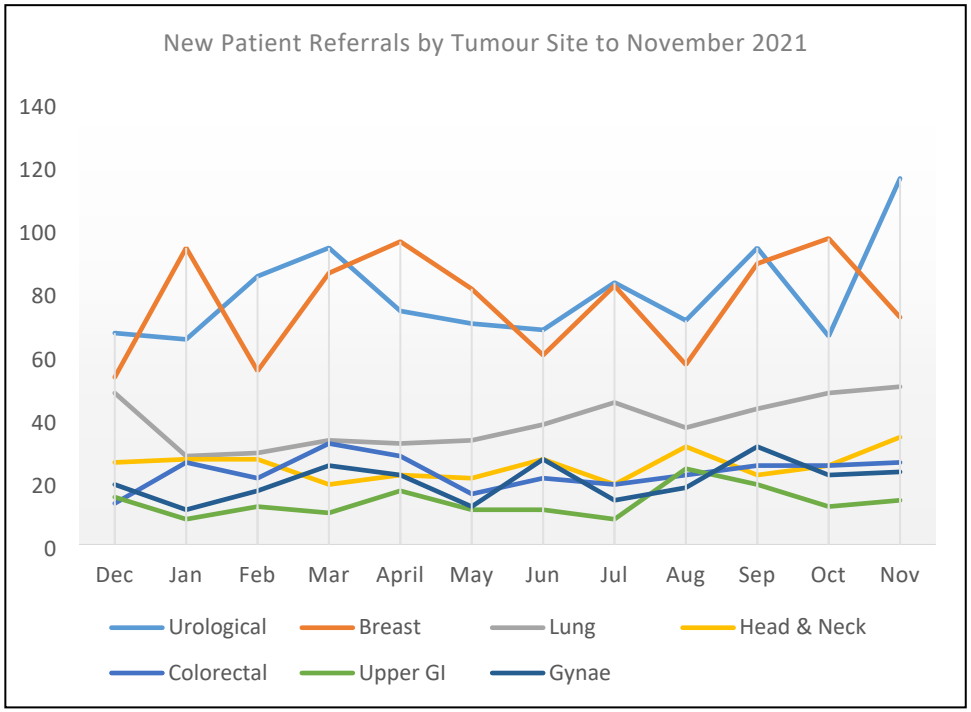


Monthly Average (2019-20)	Monthly Average (2020-21)	Total New Patient Referrals (November 2021)
357	315	404

The total number of referrals received in November 2021 (404) represented a marked increase relative to the previous month (351). The number of new referrals in November far exceeded the average number received in any given month in 2020/21 (315).

Radiotherapy – Operational Context

Referral Trends - Tumour Site



Site	Monthly Average (2019-20)	Monthly Average (2020-21)	2020-21 Average Relative to 2019-20 Average	New Patients (November 2021)
Breast	**88**	**60**	**-32%**	72
Urology	**82**	**82**	**0%**	116
Lung	**47**	**38**	**-19%**	50
Colorectal	**20**	**22**	**+10%**	26
Head and Neck	**23**	**23**	**0%**	34
Gynaecological	**18**	**18**	**0%**	23
Upper Gastrointestinal	**16**	**13**	**- 19%**	14
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**82%**	**81%**		76%

The graph and table show the number of patients scheduled to begin treatment in September by the tumour sites most commonly referred for radiotherapy treatment.

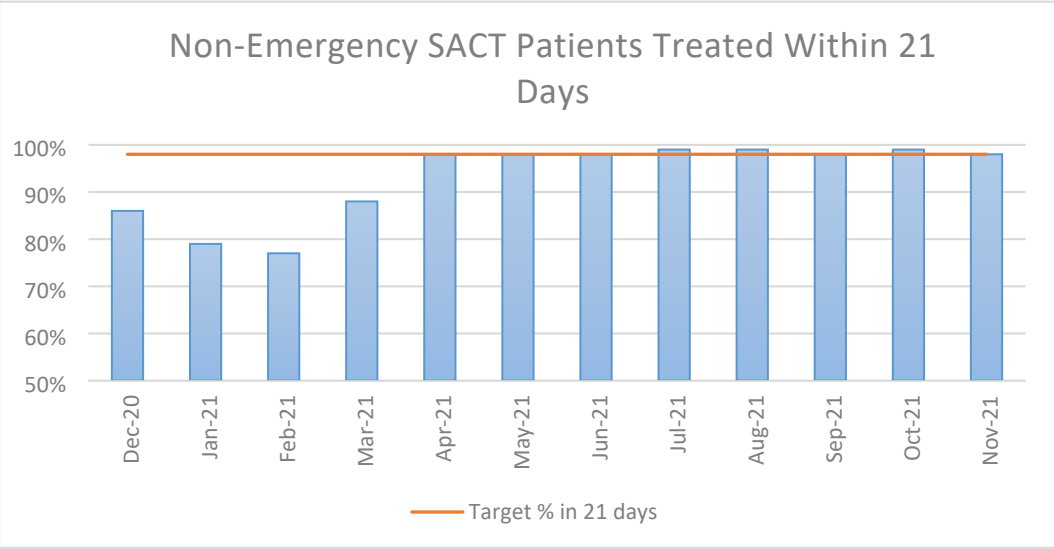
- Referrals overall and across most tumour sites now back to pre Covid levels.
- Surges in referrals weekly from health boards occurring across individual tumour sites, impacting on our ability to meet demand in a timely fashion. Engagement with health boards ongoing to understand their backlog clearance plans.
- All options being explored by SSTs to meet short term surges and to respond to health board backlog clearance.

Non-Emergency SACT Patients Treated Within 21-Days

Target: 98%

SLT Lead: Chief Pharmacist

Current Performance



The number of patients scheduled to begin non-emergency SACT treatment in November 2021 (372) was equal to the monthly average observed in 2020-21 (298) but below the number scheduled to begin treatment in November 2020 (382).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (November 2021)
Non - emergency	328	298	372
	Patients Scheduled to Begin Treatment (November 2019)	Patients Scheduled to Begin Treatment (November 2020)	
		353	

Trend

372 patients were referred for non-emergency SACT treatment were scheduled to begin treatment in November. Of this total, 5 patients did not begin treatment within the 21 day target, due to capacity challenges, constituting an overall performance rate of 98%.

The 5 patients who did not begin treatment within 21 days, commenced their treatment as follows:

Treatment Intent	≤ 28 days
Non-emergency (21-day target)	5

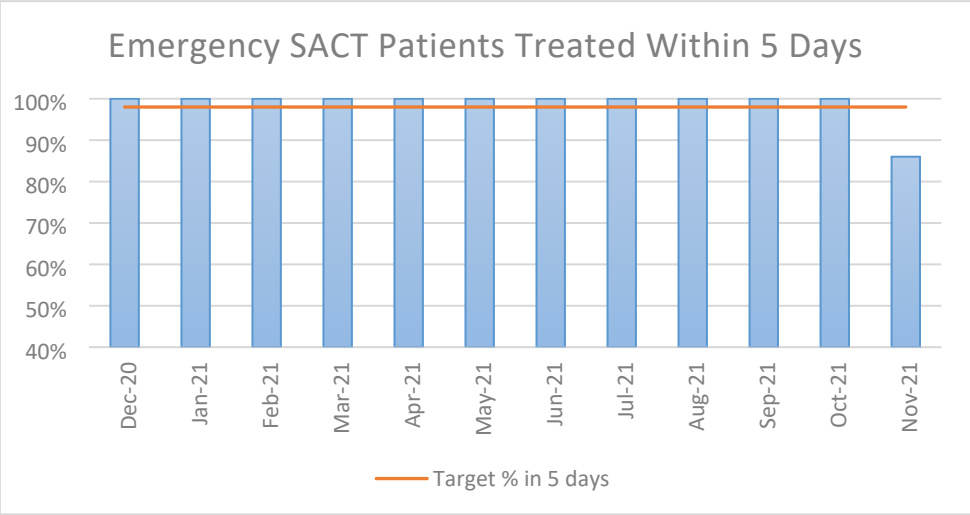
Actions

This position has been achieved through:

- Improvements in booking processes.
- Maximising capacity through pre-empting non-attendance rates and overbooking to a compensatory level.
- Improved utilisation of chair capacity across VCC site.
- Additional day on Tenovus mobile unit.
- Increases in oral SACT volumes.
- Streamlined management of non-chair activity, e.g. Sub cutaneous injections.

Delivery of plan focused on reopening Neville Hall SACT delivery capacity (Delayed from May 2021. Anticipated delivery in November 2021 due to facility and logistical issues at Neville Hall has been further delayed).

Emergency SACT Patients Treated Within 5-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**
Current Performance	Trend



The number of patients scheduled to begin emergency SACT treatment in October 2021 (7) was higher than the monthly average observed in 2020-21 (4).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (November 2021)
Emergency	4	4	7
	Patients Scheduled to Begin Treatment (November 2019)	Patients Scheduled to Begin Treatment (November 2020)	
		5	

7 patients referred for emergency SACT treatment were scheduled to begin treatment in November 2021. 2 patients did not begin treatment within the target time. These patients began treatment on day 6 and day 7 with the agreement of clinicians.

- Ring fencing of emergency chair capacity has allowed us to improve the compliance in this area. This took a number of months until the correct balance between ring fencing and chair utilisation was achieved.

Actions

- Continue to balance demand and ring fencing with capacity.

SACT – Operational Context

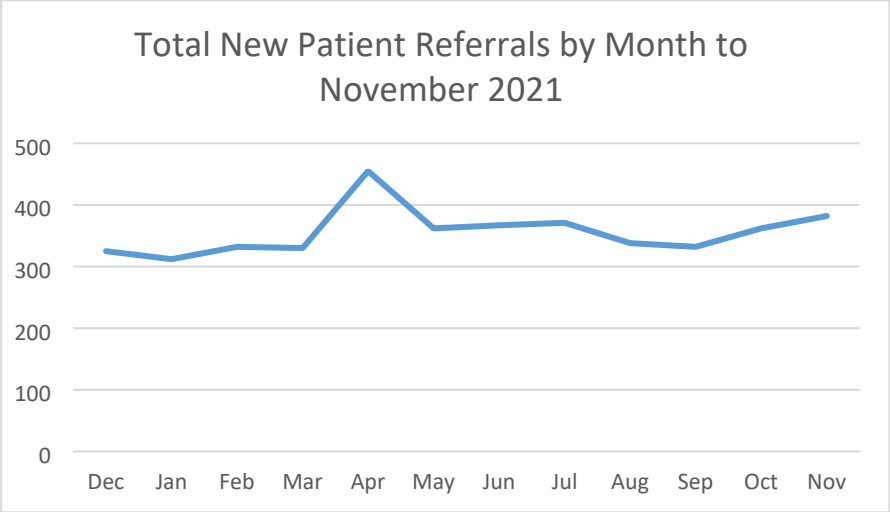
Current Performance Consolidated

Measure	Target	Nov-21
Non-emergency (21-day target)	98%	**99%**
Emergency (5-day target)	98%	**86%**

The table shown here sets-out performance relative to the extant time to SACT targets.

Social distancing and other infection control measures present particular challenges in the delivery of SACT. Additionally, overall delivery capacity remains restricted. All services, previously delivered in outreach contexts, were repatriated to VCC in response to the pandemic. With the exception of a limited service at the Macmillan Unit at the Prince Charles Hospital in Merthyr Tydfil, this remains the case.

Referral Trends - Overall



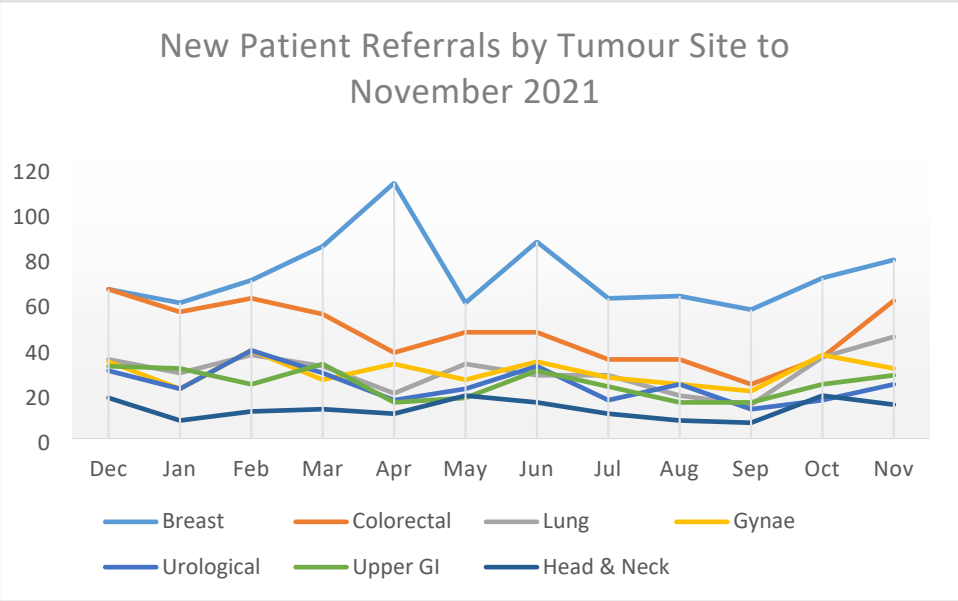
Monthly Average (2019-20)	Monthly Average (2020-21)	Total New Patient Referrals (November 2021)
325	301	382

The total number of referrals received in November 2021 (382) was above the average number received in any given month during 2020-21 (301) and exceeded the number received in October 2021 (362). The number of referrals received in November also exceeds the average number received per month in 2019-20.

Referrals fell dramatically following the first national lock-down in March 2020. Subsequently, referrals have returned to pre-pandemic levels.
Referrals include new patients for 1st definitive treatment and repeat treatments for patients mid cycle or on a revised treatment cycle.

SACT – Operational Context

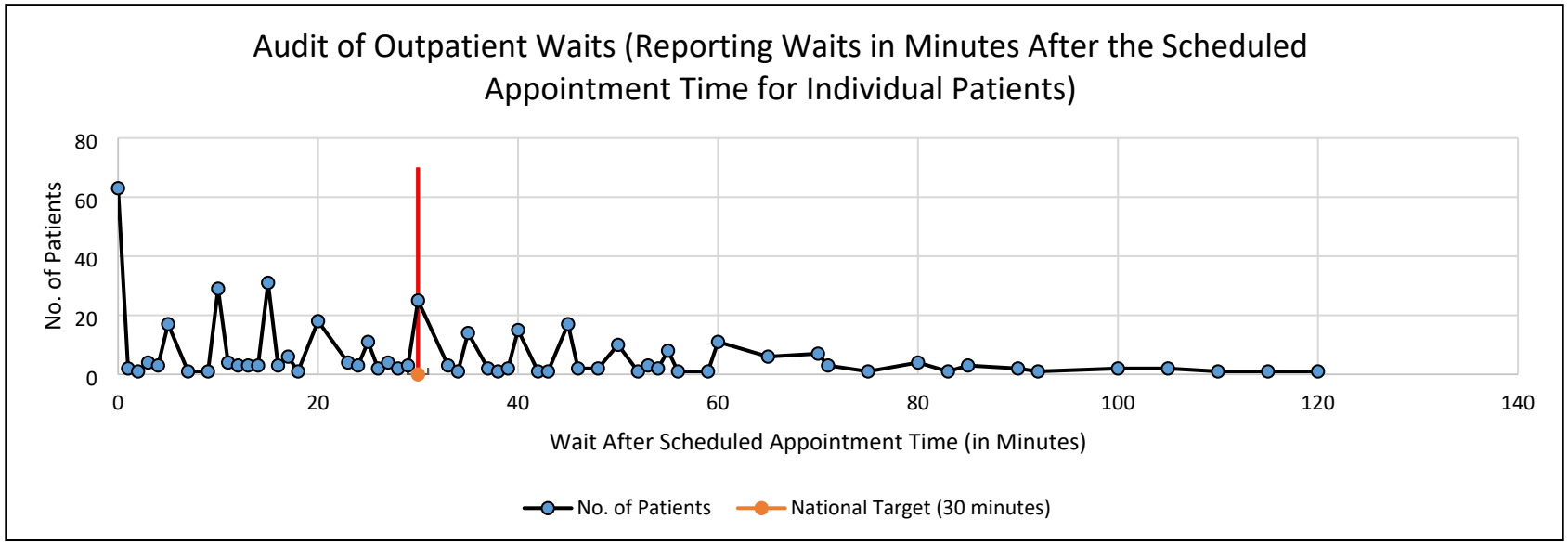
Referral Trends - Tumour Site



Site	Monthly Average (2019-20)	Monthly Average (2020-21)	2020-21 Average Relative to 2019-20 Average	New Patient Referrals (November 2021)
Breast	**92**	**76**	**-17%**	79
Colorectal	**54**	**55**	**+2%**	61
Lung	**33**	**32**	**-3%**	45
Gynaecological	**31**	**31**	**0**	31
Urological	**36**	**26**	**-28%**	24
Upper Gastrointestinal	**18**	**26**	**+44%**	28
Head and Neck	**16**	**14**	**-12%**	15
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**86%**	**87%**		74%

The graph and table show referrals for the tumour sites most commonly referred for SACT treatment.
SACT referrals are being driven by a high level of internal demand as a result of new/combination regimens, increasing patient treatment cycles etc.

New Patient, Other Outpatient and Chemotherapy Assessment Appointments Where Patients Were Seen Within 30 minutes of the Scheduled Appointment Times (National Target)	
Target: 100%	**SLT Lead: Director of Operations**
Current Performance	



Total	No. of Patients Subject to No Wait	Median Wait (50% of Patients Seen)	Mean (Average) Wait	No. of Patients Seen Within 30 Minutes	Longest Wait
389	63 (17%)	20 minutes	27 minutes	247 (65%)	120 minutes (1 patient)

This data is obtained from a manual data collection exercise undertaken by nursing staff for one week each month. This can result in some clinic and waiting time data not being fully captured. The exercise relates only to face-to-face appointments and does not capture virtual interactions

Trend	Actions
Outpatient activity delivered in outreach contexts prior to the advent of the COVID-19 pandemic was repatriated to VCC. Demand for phlebotomy services at VCC, typically delivered in primary and secondary care contexts prior to the pandemic, continues to be extremely high. Longest patient wait (148 minutes) was a complex patient pathway requiring appointment time with Clinical Nurse Specialist, non-medical prescriber and Consultant. The ratio of face-to-face to virtual appointments remains at approximately 50:50. Vacutainer supply issues have delayed the repatriation of some phlebotomy activity to primary care contexts.	• Capital funding has been secured to undertake environmental improvement work in the department. • A number of options have been identified (by a previously commissioned consultant) which are intended to release capacity and aid patient flow. Business case to be developed (February 2022). • Work is being undertaken to map patient flow which will form the basis of an improvement project (January 2022).

Equitable and Timely Access to Services - Therapies	
Target: 100%	**SLT Lead: Head of Nursing**

Current Performance

Percentage of Therapies Referrals (Inpatients) Seen Within 2 Working Days

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Dietetics	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks

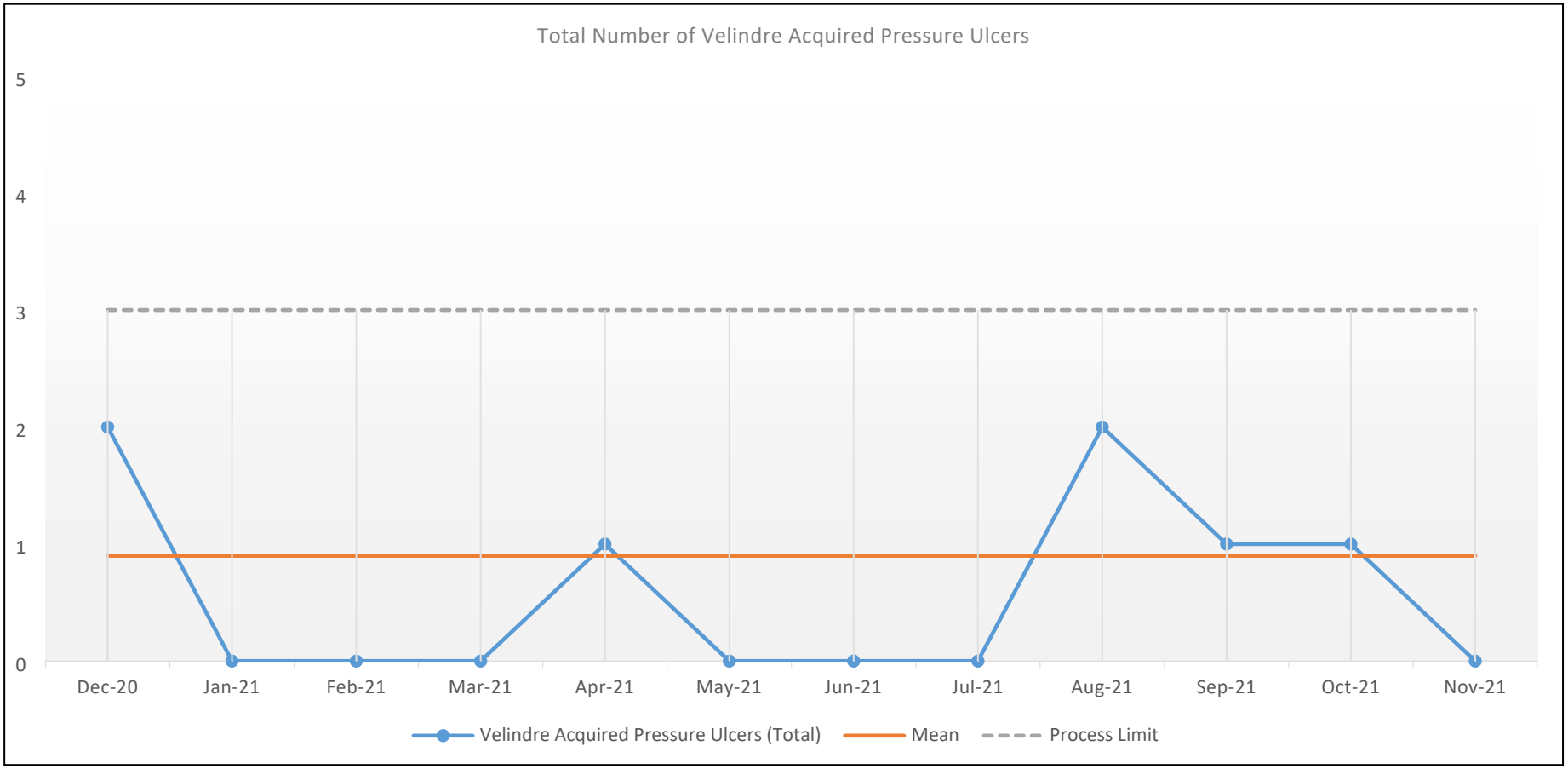
	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Dietetics	97%	100%	100%	100%	100%	100%	84%	94%	94%	98%	97%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	96%	33%	78%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	96%	100%

All Therapies targets were achieved in November 2021.

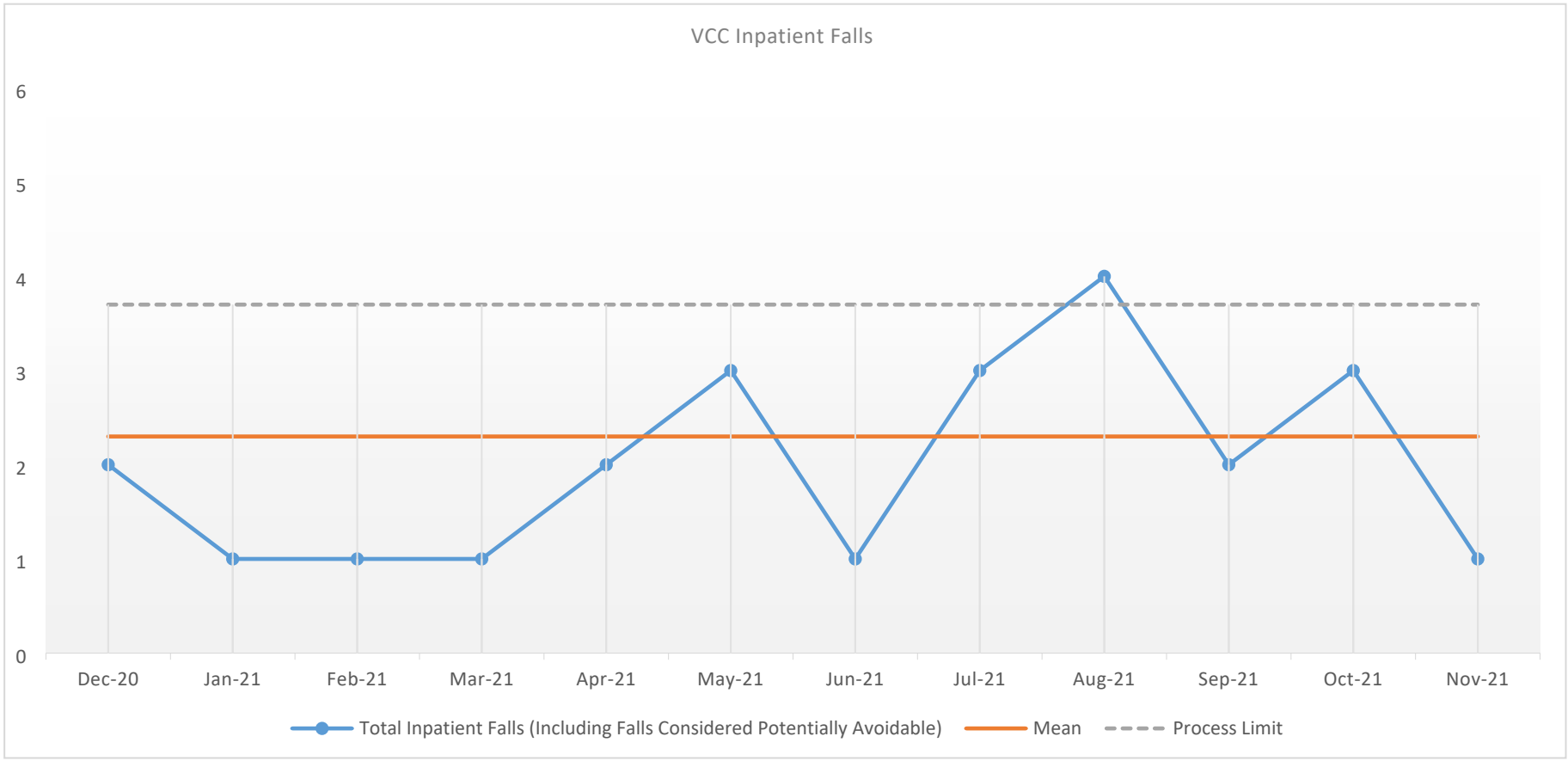
Velindre Acquired Pressure Ulcers	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Velindre Acquired Pressure Ulcers (Total)	1	3	2	2	0	0	0	1	0	0	0	2	1	1	0
Potentially Avoidable Velindre Acquired Pressure Ulcers	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0

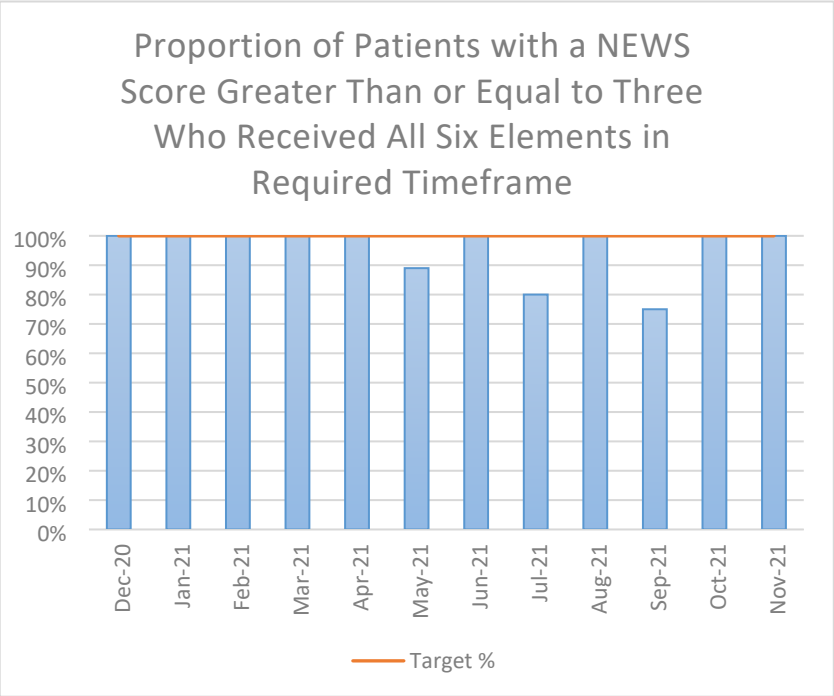
Trend	Action
NO Velindre acquired pressure ulcers reported in November 2021. No Velindre acquired ulcers were reported to Welsh Government as a Serious Incident (SI).	No specific action required.

Velindre Inpatient Falls	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Total Inpatient Falls	3	4	0	2	1	1	1	2	3	1	3	4	2	3	1
Potentially Avoidable Inpatient Falls	0	1	0	0	0	0	0	1	0	0	0	0	1	0	0

Trend	Action
During November 2021 there 1 fall was reported on first floor ward, A full investigation was undertaken by the VCC Falls Scrutiny Panel. Following investigation, the fall was deemed to have been unavoidable.	The patient had been the subject of a falls risk assessment on admission, but mobilised without staff assistance and fell. • Following the incident the falls pathway was completed and the patient reviewed by a medic. • The patient experienced no harm.

Patients with a NEWS Score Greater Than or Equal to Three Who Receive All 6 Elements in Required Timeframe	
Target: 100%	**SMT Lead: Clinical Director**
Current Performance	Trend
	Twelve patients met the criteria for administration of the sepsis treatment bundle in November 2021. All twelve received all elements of the bundle within one hour. Five of the patients subsequently received a diagnosis of sepsis or neutropenic sepsis.
	Actions
	No specific action required.

Healthcare Acquired Infections (HAIs)	
Target: 0	**SLT Lead: Clinical Director**

Current Performance

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
C.diff	0	1	0	0	0	0	0	1	0	0	0	0
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0
E.coli	0	0	0	0	0	0	0	0	0	0	0	0
Klebsiella	0	0	0	0	0	0	0	0	0	0	0	0
Pseudomonas Aeruginosa	0	0	0	0	0	0	0	0	0	0	0	0

Trend	Action
No healthcare acquired infections were reported in November 2021.	

Welsh Blood Service Monthly Report

November 2021

Gwasanaeth Gwaed Cymru
Welsh Blood Service

- All demand for red cells was met, and all stock groups continued to be maintained above 3 days and averaging at 1409 units per week, representing a reduction in demand from the previous month.
- All clinical demand for platelets was met averaging 199 units per week in November, compared to 211 for October.
- Monday 8th November marked the first peripheral blood stem cell collection performed by the Welsh Bone Marrow Donor Registry at the new collection centre within Velindre Cancer Centre.
- The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 210 for November. The inability to hold whole blood donation clinics in schools and Universities continues to hinder recruitment, however, the Service is actively considering a new strategy to improve this performance.
- At 97%, the turnaround time for routine Antenatal tests in November remains above the target of 90%.
- There is a 5% improvement for the Red Cell testing metric in November. Work continues to prioritise clinical need with all compatibility testing (>50% of referrals) completed to the required time/date. The Service workload audit continues to progres s.
- At 0.92 Collection Productivity for November is higher than October (0.86) but continues to be below target. The ongoing COVID 19 response need to resource Triage at donation clinics and short term staff absences due to Covid is causing a reduction in session capacity in North Wales, impacting performance for November.
- At 2.40 % for November, the combined 'Part Bag' rate has increased and is higher than October (2.27%) but remains within the tolerance level. The Failed Venepuncture (FVP) rate for November has increased to 1.60 % compared to 1.37% for October but also remains within the tolerance threshold of 2%. Evaluation is taking place to establish the need for any interventions.
- At 96% the performance against the 'Incidents closed within 30 days' measure has exceeded target (90%) for the three month rolling period to November.
- There were two Serious Adverse Events (SAE) reported to the HTA (Human Tissues Authority) in November. Both events are related to Stem Cell Collection and have been investigated to establish root cause and corrective actions identified and completed.
- At 424.30 the manufactoring perfomence for November is closer to the target of 392.00 than the October performance of 325.30. The November performance reflects pressure on existing staffing numbers as a result of increased sickness and support provided for vaccine distribution.
- In November ten concerns (0.13%) from Blood Donors were reported and nine were managed within timeline as early resolution. The one formal concern is being managed under 'Putting Things Right' (PTR) regulations and is expected to be completed before the 30 day target of 28/12/21.
- In November overall donor satisfaction reached 97.2%. In total there were 819 respondents who had made a full donation and shared their donation experience, 135 were from North Wales and 650 were from South Wales.

12 Key Performance Indicators were above the previous month's performance, 8 achieving target

4 Key Performance Indicators remained the same as the previous month's performance, all achieving target.

5 Key Performance Indicators were down on the previous month's performance, with 4 achieving target..

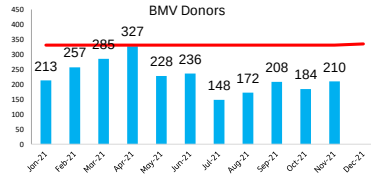
Reference Table

Measure	Target	Timeframe	National / Local
Number of new bone marrow donors aged 18-30 recruited to the Welsh Bone Marrow Donor Registry (WBMDR)	4,000	Annual	Local
Number of days when the Red Blood Cell (RBC) stockholding for O, A & B- fell below 3 days cover	0 days	Monthly	Local
Number of bags of RBCs manufactured as a % of the number of issues to hospitals **(% Red Cell Demand Met)**	100%	Monthly	Local
Number of bags of platelets manufactured as a % of the number of issues to hospitals **(% Platelet Demand Met)**	100%	Monthly	Local
Number of Confirmatory Tests (CTs) requested and bled as a % of the total CTs requested **(Confirmatory Tests Bled)**	65%	Monthly	Local
Number of Stem Cell Collections	80	Annual	Local
Number of antenatal patient results provided to customer hospitals within 3 working days from receipt of sample **(Antenatal Turnaround Times)**	90%	Monthly	Local
Number of samples referred for red cell reference serology work ups provided to customer hospitals within 2 working days. **(Reference Serology Turnaround Times)**	80%	Monthly	Local
% of Quality Incident Records (recorded in DATIX), closed within 30 days over a rolling 3 month period	90%	Rolling	Local
Number of critical non-conformances through external audits or inspections	0	Annual	Local
Number of Serious Adverse Blood Reactions & Events (SABRE) reported to the Medicines and Healthcare products Regulatory Agency (MHRA)	0	Annual	Local
Number of whole blood donations that are collected on session which are below the minimum viable volume, as a % of the total number of whole blood donations collected **(% Part Bags)**	3%	Monthly	Local
Number of donors where venepuncture is attempted to be performed on but no blood enters the bag, as a % of the number of donors who have reached the donation chair **(% Unsuccessful Venepuncture)**	2%	Monthly	Local
The number of blood components (weighted) collected per Standardised FTE (**Blood Collection Efficiency)**	1.25 WTE	Monthly	Local
Number of components manufactured per Standardised FTE. **(Manufacturing Efficiency)**	392	Monthly	Local
Number of platelets which have time expired as a % of the total number of platelets manufactured **(Time Expired Platelets)**	10%	Monthly	Local
Number of RBC units which become non-viable during the manufacturing process which could have been avoided, as a % of the number of complete whole blood donations **(Controllable Manufacturing Losses)**	0.5%	Monthly	Local
Number of bags of RBC, including Paediatric bags, which have time expired as a % of the total number of RBC bags manufactured **(Time Expired Red Cells)**	1%	Monthly	Local
Number of donors that scored 5 or 6 out of 6 (6 being totally satisfied and 1 being totally dissatisfied with their overall donation experience after they have been registered on clinic to donate **(Donor Satisfaction)**	71%	Monthly	Local
Number of 'formal' and 'informal' concerns received from blood donors	~	~	~
% of 'formal' concerns received and treated under 'Putting things Right Regulations within 30 working days	100%	Monthly	National
% of all concerns (formal and informal) acknowledged within 2 working days as required by the 'Putting things Right' Regulations	100%	Monthly	National
Number of new Whole Blood Donors recruited to the donor panel	2,750	Quarterly	Local
Number of new Apheresis Donors recruited to the donor panel	14	Quarterly	Local
Number of Deceased Donor Typing / Cross Matching reported within given period	80%	Quarterly	Local
Number of Anti D & -c Quantitation patient results provided to customer hospitals within 5 working days	90%	Quarterly	Local

Monthly Reporting

Equitable and Timely Access to Services

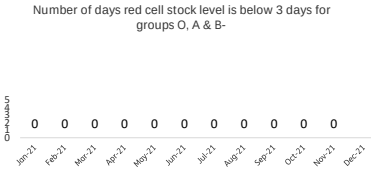
Nov-21



Annual Target: 4000 (ave 333 per month)	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Action (s) being taken to improve performance	By When
There were 210 new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) in November. The inability to hold whole blood donation clinics in schools and Universities, continues to hinder recruitment of new BMV's (Bone Marrow Volunteers).	The new donor recruitment and retention strategy for the WBMDR became live on 03/08/2021. Further work to raise the public awareness of the strategy to support the desired increase in volunteers is currently being reviewed. WBS SMT has agreed to promote the 'Swab Recruitment' in the main Universities in Wales in an attempt to meet the monthly target of 333 donor recruitments. This work is currently being carried out. WMBDR Communications Group meetings have been established to take place monthly to support raising the profile of this collection.	A new system is in place since 03/08/2021, ongoing monitoring and review in March 2022 to take place

Safe and Reliable Service

Nov-21

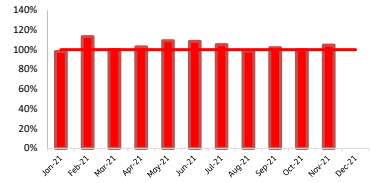


Monthly Target: 0	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
All stock groups continue to be maintained above 3 days for November	Daily Resilience meetings held between blood Collection, Manufacturing/Distribution and the Blood Health teams continue to facilitate operational responses to the challenges in maintaining adequate stock levels to minimise blood shortages.	Business as Usual, reviewed daily

Safe and Reliable service

Nov-21

% Red Cell Demand Met

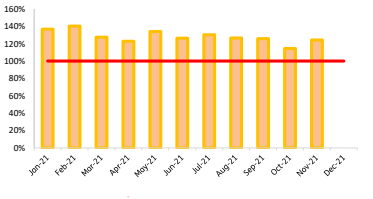


Monthly Target: 100%	SMT Lead: Jayne Davey/ Tracey Rees	
What are the reasons for performance?	Actions(s) being taken to improve performance	By When
All demand for red cells was met. Factors affecting the supply chain include Covid restrictions, winter pressures and staff absence. Close collaborations between the Collections and Laboratory teams continues to enable agile responses to variations of stock levels and service needs. Demand in November (full weeks) averaged at 1409 units per week.	Daily Resilience meetings held between blood Collection, Manufacturing/Distribution and the Blood Health teams continue to facilitate operational responses to the challenges in maintaining adequate stock levels to minimise blood shortages.	Business as Usual, reviewed daily

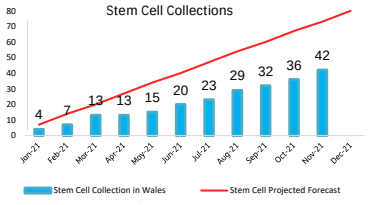
Safe and Reliable service

Nov-21

% Platelets Demand Met



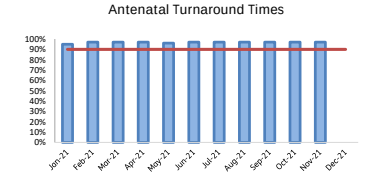
Monthly Target: 100%	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Actions(s) being taken to improve performance	By When
All clinical demand for platelets was met. Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs. Platelet demand was 199 units per week on average.	The Ambient Overnight Hold (AONH) production process allows flexibility in the production plan for platelets. Adjustments on the weekly production continue to be made to align with demand.	Business as Usual, reviewed daily



Safe and Reliable service

Nov-21

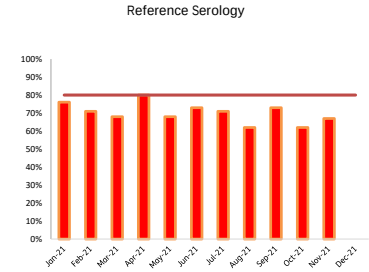
Annual Target: 80 (ave 7 per month)	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were 6 Stem Cell Collections in November, 5 by the Peripheral Blood Stem Cells (PBSC) collection method and 1 by bone marrow harvest. There were 3 cancellations at the preparation/work up stage which has impacted on collection performance for November, and the Year to Date target.	The first stem cell collection via apheresis took place on 8th November at Velindre Cancer Centre. The pandemic has resulted in a global impact on transplants being delivered. The Service is taking time to return to business as usual. WBS has commenced defining and agreeing a future strategy for Stem Cell collection as part of wider review of future strategy for the Welsh Bone Marrow Donor Registry.	30/06/2022



Safe and Reliable service

Nov-21

Monthly Target: 90%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 97%, the turnaround time for routine Antenatal tests in November remains above the target of 90% Continued monitoring and active management remains in place.	Continuation of existing processes are maintaining high performance against current target.	Business as Usual, reviewed daily



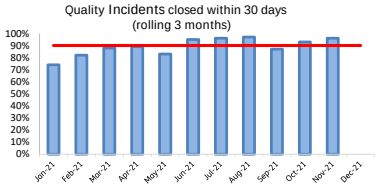
Safe and Reliable service

Nov-21

Monthly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Turn around times have not met target for November. Work continues to be prioritised based on clinical need, and all compatibility testing (>50% of referrals) is completed to the required time/date. Whilst performance did improve, the complexity of referrals, sickness absence, 'Out of Hours' responses and the resulting impact on day to day work impacted performance in November. There were 255 hospital patient referrals in November, with the average number of Hospital Patient referrals at 221/month for 2021 to date, compared to 181 in 2020.	WBS is conducting an audit which is focussing upon the appropriateness of out of hours hospital referrals based on haemoglobin and diagnosis, the urgency of transfusion, how long samples take to reach WBS, if there is any 'overordering', and multiple requests for patients . The results of the audit are not expected to be available until end of January 2022. The implementation of a project aimed to increase automation in RCI (Red Cell Immunohematology) is also anticipated to improve performance in this area.	30/01/2022 Date yet to be decided due to ongoing scoping project work.

Safe and Reliable service

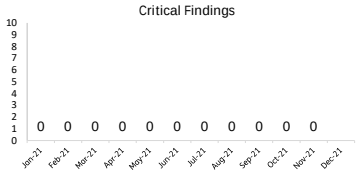
Nov-21



Monthly Target: 90%	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 96% the performance against the 'Incidents closed within 30 days' measure exceeded target (90%) for the three month rolling period to November. The September performance against this measure continues to influence the three month rolling performance .	The revised process for managing low-impact incidents was implemented on 1st June, new reports are reviewed and risk assessed daily and the majority of incidents are fully closed within a few days of reporting. Datix User Access and Reporting issues remain with the Datix Project Board for resolution.	Continue with close monitoring.

Safe and Reliable service

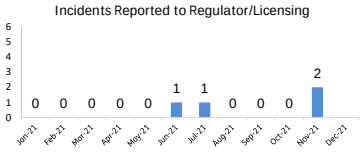
Nov-21



What are the reasons for performance?	Action(s) being taken to improve performance	By When
UKAS undertook an ISO 15189 'Extension to Scope' audit of the WTAIL HPA (Human Platelet Antigen) testing process in November. There were no critical findings from this audit.	The HPA testing process will be audited in December 2021. All previous UKAS findings have been cleared. Actions from previous MHRA inspections are being managed as business as usual via action plans.	Completed.

Safe and Reliable service

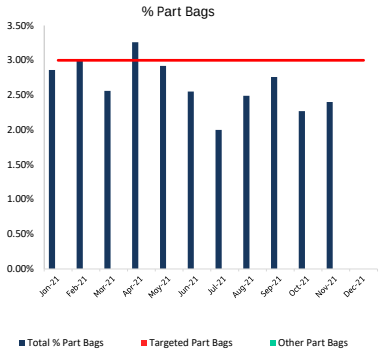
Nov-21



Annual Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were two Serious Adverse Events (SAE) reported to the HTA (Human Tissues Authority) in November, both involve Stem Cell Donors. The incidents were reported to the HTA and Datix. One is classified as a 'Medication/IV fluids- Administration Error', whilst the other as 'Treatment or Procedure Issues.' System notifications have been issued to relevant staff members, including the Senior staff at Trust and WBS. Details of each event, the root cause analysis and subsequent corrective and preventive actions are recorded in Datix. The Donor involved in the Medication/IV fluids- Administration Error was informed immediately, at the time the event occurred, and did not suffer any adverse effects. The Donor involved in the Treatment or Procedure Issue was hospitalised due to a low platelet count, but discharged the following day, with another platelet count due to be undertaken by WBMDR nurses at two weeks post-discharge.	Corrective and preventive action for the 'Medication/IV fluids- Administration Error' has been defined as: •Member of staff involved in the error has completed reflective practice •Calcium Gluconate is now quarantined in a specific and consistent space within the drug cabinet •All staff will now use a pre-filled sodium chloride syringe, rather than ampoules •The process requires a two person check for IV drug administration is required and will be evidenced by a signature The Head of Welsh Bone Marrow Donor Registry has advised that both HTA reports are closed.	Completed.

Spending Every Pound Well

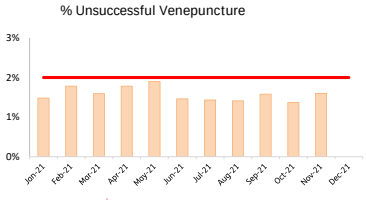
Nov-21



Monthly Target: Maximum 3%	SMT Lead: Janet Birchall	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 2.40% for November, the combined 'Part Bag' rate remains within the required tolerance level. Analysis indicates a downward trend for 'South East A' & 'South East B' team performance against this measure. South Wales East C and the Stock Building teams are over tolerance for November at 3.1% and 3.6% respectively. The Stock Building team collect low volumes and the tolerance breach represents 3 part bag events. Investigation of South East C Team performance has identified 4 venepuncturists with higher part bag events than others. Further analysis is now taking place to confirm the significance of this finding. Movement of staff between East teams can make it more difficult to track this performance measure. Causes of Part Bag are various and include: needle placement, donor is unwell, donor request to stop donation, and equipment failure. This is a separate factor to FVPs.	Analysis has identified the performance of four venepuncturists influencing South East C performance. Operation Managers & the Training Team are evaluating the information, and should it be required further interventions (I.e. Individual Support Plans and or Additional Training /Supervision) can be actioned.	31/01/2022

Spending Every Pound Well

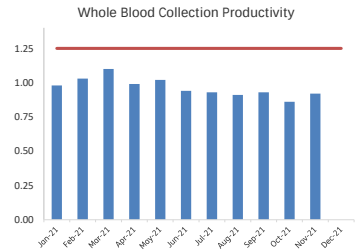
Nov-21



Monthly Target: Maximum 2%	SMT Lead: Janet Birchall	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The overall Failed Venepuncture (FVP) rate for November is at 1.60 %, an increase compared to October (1.37%) but remains within the tolerance threshold of 2%. The performance trend of the 'South East A' team is now showing an improvement, whilst the 'South East C' team is at tolerance (22 FVP events) and Wrexham team is over tolerance at 2.3% (18 FVP events). The 'Stock Building' team performance is at 2.4% (2 FVP events).	Performance analysis of the Wrexham and South East C teams has identified two venepuncturists of each team with higher FVP rates. Operation Managers & the Training Team are evaluating the information, and should it be required further interventions (I.e. Individual Support Plans and or Additional Training /Supervision) can be actioned. Ongoing monitoring of the Stock Building team performance.	31/01/2022

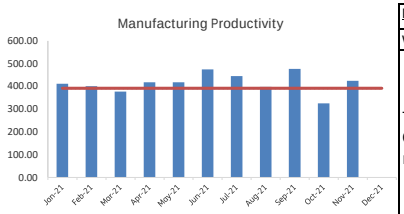
Spending Every Pound Well

Nov-21



Monthly Target: 1.25	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 0.92 collection productivity for November is higher than October (0.86) but continues to be below target. In November several staff resigned from the Service and recruitment is ongoing to replace them. Covid and Infection Prevention Control (IPC) measures continue to limit donation centre capacity. Meanwhile short term staff absences due to Covid, combined with the reduction in session capacity in North Wales due to staff unavailability has impacted performance for November. There are also regional variations in productivity across collection teams which the Service is reviewing, and in part is attributable to skill mix and regional team location.	Whilst the Service continues to operate under Covid conditions, it is extremely limited in being able to improve this performance. Robust sickness management of staff continues and productivity measures will be considered for the Divsion's new Performance Management Framework.	Q1 2022

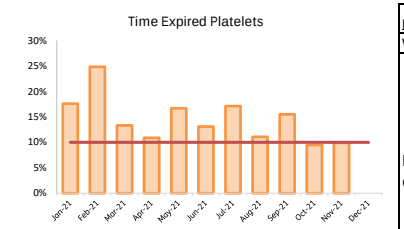
Spending Every Pound Well



Monthly Target 392	SMT Lead: Tracey Rees	
What are the reasons for performance?	Actions(s) bring taken to improve performance	By When
The November manufacturing performance figure is at 424.30 and closer to the 392.00 target than the October performance. The November performance reflects pressure on existing staffing numbers as a result of increased sickness and support provided for vaccine distribution.	This target measures the manufacturing productivity by assessing the staffing levels against the number of blood components being manufactured. This performance measure is being actively considered as part of the new Perforamnce Management Framework.	Q1 2022

Spending Every Pound Well

Nov-21



Monthly Target: Maximum 10%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Platelet expiry was within target for November, as result of carefully planned reduction in production, coupled with increased platelet requests from customer hospitals	Adjustments on the weekly production continue to be made to better align with demand and take into account the apheresis appointments and donor attendance. Ongoing platelet production is based on required daily targets, leading to decreased platelet expiry percentages.	Ongoing and reviewed daily

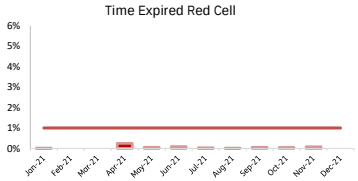
Spending Every Pound Well

Nov-21

Monthly Target: Maximum 0.5%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Controllable losses for November are at 0.1% and remain within tolerance to be below 0.5%. The losses were (units): M&D Operator - Blood Presses :3 units M&D - Heat Seal : 1 unit	Reporting and management of incidents, ongoing monitoring of losses when occurring and lessons learned analysis takes place. The metric for November is within tolerance and represents a very low percentage of processed units.	Business as Usual, reviewed monthly

Spending Every Pound Well

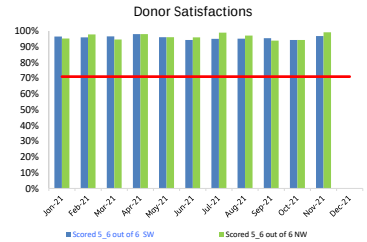
Nov-21



Monthly Target: Maximum 1%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Red cell expiry for November at 0.08% remained very low and significantly lower than the 1% target.	Effective stock management and monitoring	Business as usual, reviewed daily

First Class Donor Experience

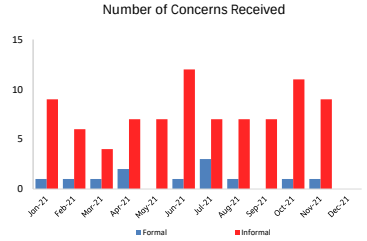
Nov-21



Monthly Target: Minimum 71%	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
In November overall donor satisfaction continued to exceed target at 97.2%. In total there were 819 respondents who had made a full donation and shared their donation experience (some of which are non attributable), 135 were from North Wales and 650 were from South Wales (where location was able to be defined).	Findings to be reported to management at Collections meeting for actions from individual teams.	Business as usual, reviewed monthly

First Class Donor Experience

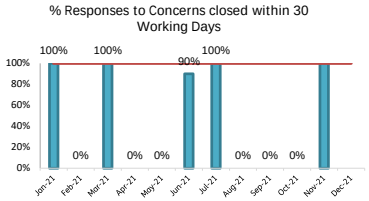
Nov-21



Target: N/A	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
In November 2021, approximately 7,500 donors were registered at donation clinics. 10 concerns (0.13%) were reported within this period, 9 were managed within timeline as early resolution as detailed below. One formal concern recorded in November is being managed under 'Putting Things Right' (PTR) regulations and is expected to be completed before the 30 day target of 28/12/21. The formal concern recorded in October was managed under 'Putting Things Right' (PTR) regulations and was completed 16/11/21, 14 days before the 30 day target of 03/012/21. 1. Donor unhappy the mobile unit does not visit convenient areas of North Wales and enquired whether any consideration has been given to reviewing the decision 2. Donor unhappy with staff approach to wearing a face covering when donor exempt. 3. Two donors booked appointment online, and were turned away at clinic for 'being too soon to donate'. 4. Donor unhappy with lack of gluten free options in post donation care area and information given by staff on ingredient of biscuits 5. Donor was unhappy with staff approach to questioning regarding providing contact details 6. Donor was unhappy with age deferral for donors over the age of 70 years 7. Donor was unhappy with the lack of appropriate awareness of a session being cancelled 8. Donor unhappy with lack of information on website for donors who have ever injected anabolic steroids 9. Donor was unhappy with being turned away from session for being late for appointment	Actions taken to address Concerns: 1. Formal letter issued to explain the reason mobile units are not operating at this time, and further information will be sent to all donors once an update is available. 2. Reception & security staff reminded of the current process for accepting donors who are medically exempt from wearing a face covering when arriving at Talbot Green Centre. 3. A full explanation was provided to the Donor regarding online booking and the process in place to identify donors who book appointments too soon following their most recent donation. 4. Team staff reminded to order enough gluten free options from stores, staff also reminded not to advise donors on the ingredient of biscuits provided. 5. IT have advised that there is now way of recording this information on the WBS system for those donors who do not wish to share their details. WBS staff reminded to be mindful of donor wishes regarding disclosure of personal details at donation. 6. The donor was contacted to discuss and the deferral reviewed and lifted. The donor is able to donate providing acceptance criteria is met. 7. Donors were called by DCC as soon as they became aware of the situation. Unfortunately, the donor was en route and missed the call. Apologies provided to the donor who was offered alternative appointment. An update to the SMS service is being considered to mitigate against similar issues occurring in the future. 8. Work is on going to review website so users can easily identify entries relevant to their query, in addition to adding an entry for 'have you ever injected drugs'. 9. SOP, COL/111 previously updated to assist staff manage this scenario. Full apology given to donor and another appointment made	Business as usual, reviewed daily

First Class Donor Experience

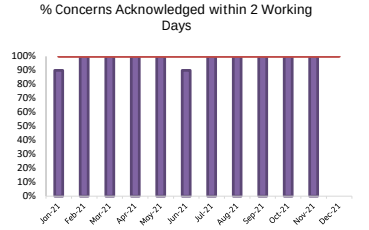
Nov-21



Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
During November 2021 one new formal concern was received. All formal concerns managed during November 2021 were closed within the 30 day Putting Things Right (PTR) requirement. * Under PTR, Organisations have 30 working days to address/ close formal concerns. This can result in concerns being received and subsequently closed within separate reporting periods.	Continue to monitor Formal complaint response progress, and 30 day target compliance.	Business as Usual, reviewed daily

First Class Donor Experience

Nov-21



Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
All initial responses to all early resolution and formal concerns received in November 2021 were managed within timeline.	Continue to monitor initial complaint acknowledgement progress against the 'two working day' target compliance.	ongoing, reviewed daily

Workforce Monthly Report

November 2021

Workforce Report provides the following:

- Overview of Key Performance Indictors for Sickness, PADR, Statutory and Mandatory training in all Divisions of the Trust, including Corporate Divisions, TCS and Research and Development (excluding hosted);
- Corporate Divisions include Finance, Workforce and OD, Corporate Estates and Planning, Corporate IT, Clinical Governance, Infection Control, Fundraising and Trust Management and Board;
- The report provides a 12 monthly trend report for Sickness, PADR, Statutory and Mandatory training;
- In month Job Planning figures with narrative to notify areas of improvement;
- Usage of Work in Confidence platform.

At a Glance for Velindre (Excluding Hosted)

Velindre (Excluding Hosted	Current Month	Previous Month	Target
	Nov-21	Oct-21	
PADR	72.11	71.69	85%
Sickness	5.48	5.36	3.54%
S&M Compliance	86.06	85.10	85%

Workforce Dashboard

Data below highlights rolling figures for workforce KPI's. This provides a running total of the values of the last 12 months of an indicator providing trend data for the indicators. Granular monthly data is generated for divisions as separate reports. Data Rag Rated for ease of reading.

Key	85%-100%		50% - 84.99%		0% - 49.99%								
These figures exclude Trainee Doctors, those on Maternity, Starters within first 6 Months, those currently off on sickness absence.													
PADR	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Corporate	45.76	47.46	39.82	41.74	43.44	45.00	49.58	47.01	48.33	50.43	45.69	46.58	44.59
Research, Development & Innovation	77.27	75.00	42.22	34.04	58.33	60.00	64.58	62.50	61.70	65.96	66.67	72.09	90.91
Transforming Cancer Services	50.00	37.50	40.00	64.29	60.00	66.67	68.75	71.43	66.67	60.00	56.25	43.75	62.50
Velindre Cancer Centre	74.23	76.98	78.68	77.53	79.78	81.07	78.88	76.52	74.31	75.17	76.40	73.77	70.90
Welsh Blood Service	69.32	66.18	67.97	73.19	77.25	78.65	82.41	81.74	79.78	78.27	77.93	77.52	82.19
Velindre Organisations	69.89	70.32	70.19	71.32	74.64	76.07	76.77	75.09	73.28	73.58	73.67	71.69	72.11
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

Key	85%-100%		50% - 84.99%		0% - 49.99%								
These figures exclude those on Maternity and those currently off with sickness absence													
Stat and Mand Compliance (10x CSTF)	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Corporate	69.45	70.47	71.61	70.62	69.47	69.06	70.08	69.08	69.26	70.45	71.36	74.54	72.32
Research, Development & Innovation	76.73	76.25	77.45	82.50	83.73	82.59	83.08	85.69	86.00	85.80	86.25	84.89	84.58
Transforming Cancer Services	70.56	70.56	71.18	69.38	64.12	65.29	70.00	76.00	76.84	85.26	82.50	82.86	83.33
Velindre Cancer Centre	80.13	80.23	80.69	81.53	81.57	80.98	81.77	82.45	82.70	83.16	82.89	83.11	84.91
Welsh Blood Service	91.67	91.42	90.43	89.54	90.90	90.43	92.23	92.39	93.38	92.66	92.21	92.54	93.36
Velindre Organisations	85.59	82.66	82.81	83.06	83.39	82.92	84.09	84.59	84.97	85.24	84.95	85.10	86.06

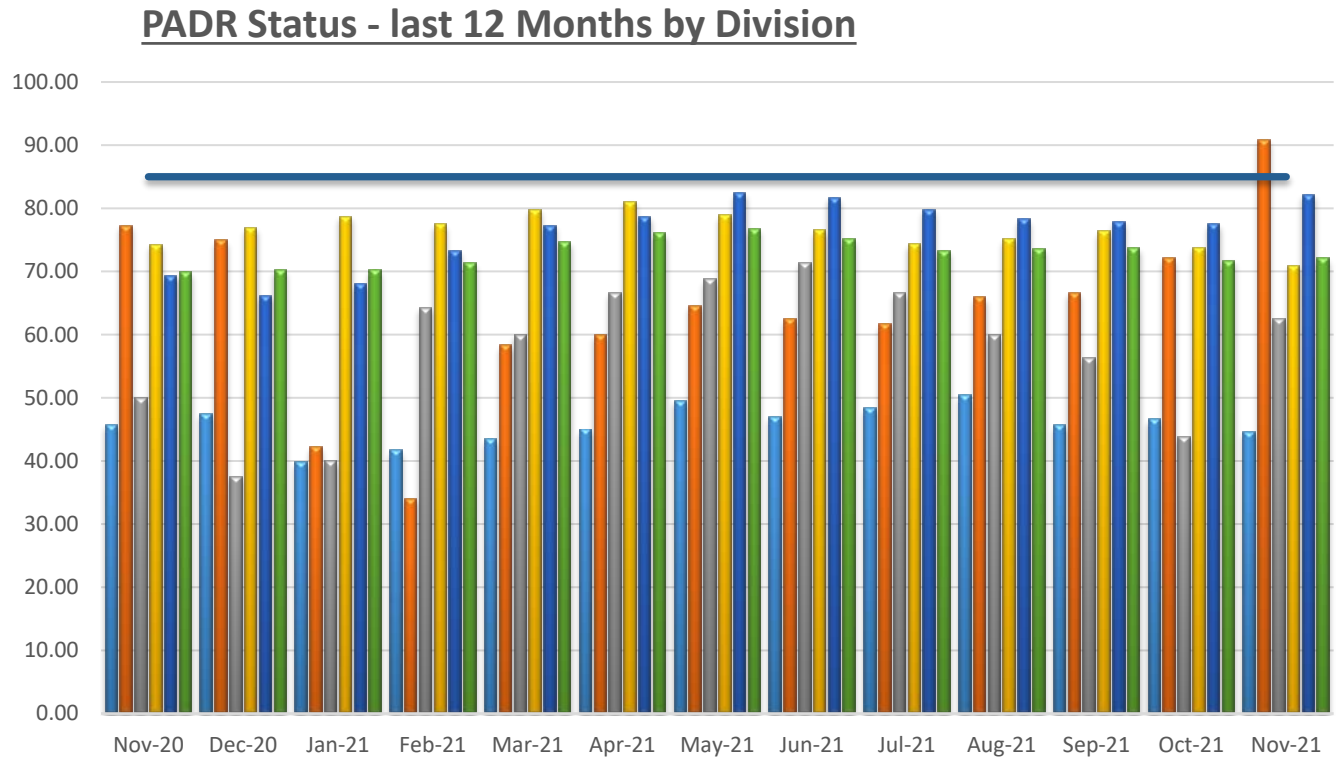
Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above								
Sickness Rolling %	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Corporate	5.18	5.20	5.24	5.14	4.85	4.59	4.51	4.44	4.33	4.13	4.15	4.13	4.29
Research, Development & Innovation	4.62	4.60	4.37	4.23	4.01	3.73	3.46	3.16	3.34	3.55	3.95	4.30	4.44
Transforming Cancer Services	2.24	2.46	2.41	2.41	2.01	1.34	0.88	0.41	0.32	0.33	0.40	0.86	1.24
Velindre Cancer Centre	5.76	5.88	5.88	5.97	5.77	5.40	5.38	5.41	5.47	5.47	5.51	5.56	5.60
Welsh Blood Service	4.43	4.43	4.44	4.38	4.24	4.19	4.36	4.57	4.81	5.10	5.41	5.69	5.95
Velindre Organisations	5.21	5.28	5.28	5.29	5.10	4.84	4.85	4.91	5.01	5.09	5.23	5.36	5.48
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54

Monthly Sickness Rolling Covid Only Absence %	0%		0.01% - 0.49%		0.50 % & Above								
Sickness Leave Covid Related	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Corporate	0.28	0.42	0.55	0.60	0.58	0.53	0.58	0.63	0.67	0.78	0.90	0.97	1.00
Research, Development & Innovation	0.36	0.43	0.45	0.46	0.42	0.35	0.44	0.45	0.45	0.43	0.43	0.43	0.42
Transforming Cancer Services	0.28	0.27	0.26	0.26	0.21	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Velindre Cancer Centre	1.09	1.28	1.39	1.44	1.31	0.96	0.89	0.86	0.87	0.88	0.85	0.87	0.85
Welsh Blood Service	0.30	0.37	0.42	0.44	0.39	0.31	0.29	0.28	0.29	0.29	0.36	0.38	0.36
Velindre Organisations	0.74	0.88	0.96	1.00	0.91	0.68	0.65	0.63	0.64	0.66	0.68	0.70	0.68

Monthly Special Leave Absence Rolling %	0%		0.01% - 0.49%		0.50 % & Above								
Special Leave Non Covid Related	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Corporate	0.38	0.37	0.30	0.23	0.17	0.11	0.05	0.04	0.06	0.06	0.03	0.09	0.09
Research, Development & Innovation	0.67	0.71	0.74	0.65	0.50	0.46	0.42	0.51	0.60	0.74	0.93	1.06	1.11
Transforming Cancer Services	0.16	0.32	0.51	0.51	0.51	0.51	0.51	0.51	0.53	0.56	0.55	0.54	0.40
Velindre Cancer Centre	0.39	0.40	0.42	0.43	0.43	0.41	0.41	0.42	0.44	0.47	0.49	0.54	0.55
Welsh Blood Service	0.57	0.62	0.63	0.61	0.62	0.58	0.59	0.58	0.59	0.61	0.63	0.65	0.66
Velindre Organisations	0.45	0.47	0.49	0.48	0.47	0.44	0.43	0.44	0.46	0.49	0.51	0.55	0.56

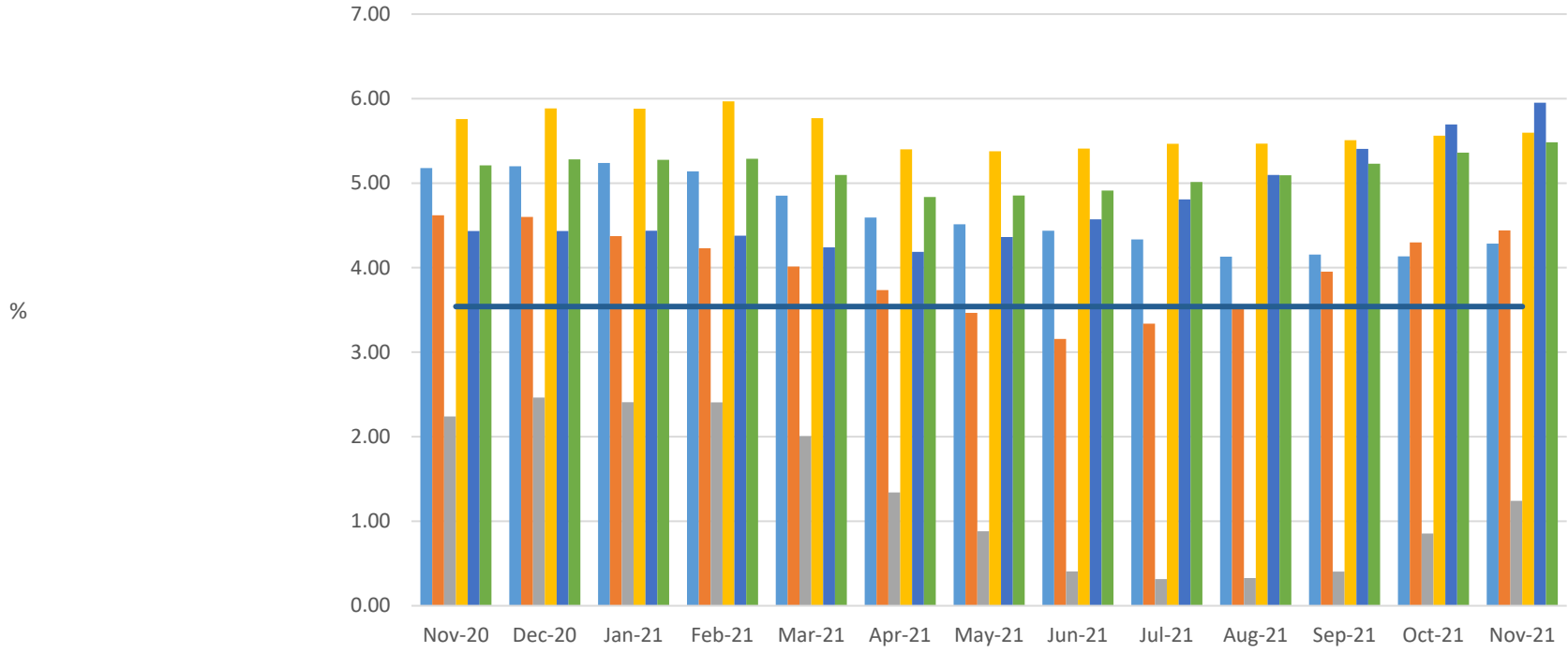
Monthly Special Leave Absence Rolling %	0%		0.01% - 0.49%		0.50 % & Above								
Special Leave Covid Related	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Corporate	0.59	0.58	0.58	0.57	0.48	0.32	0.25	0.18	0.11	0.03	0.01	0.00	0.00
Research, Development & Innovation	1.99	1.98	1.96	1.95	1.45	1.04	0.76	0.49	0.21	0.13	0.13	0.13	0.07
Transforming Cancer Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Velindre Cancer Centre	1.97	2.13	2.27	2.36	2.13	1.71	1.40	1.16	0.99	0.88	0.88	0.90	0.84
Welsh Blood Service	1.52	1.62	1.71	1.75	1.65	1.32	1.06	0.82	0.68	0.62	0.67	0.67	0.69
Velindre Organisations	1.68	1.80	1.90	1..96	1.77	1.41	1.15	0.92	0.77	0.68	0.69	0.70	0.67

PADR – The Figures



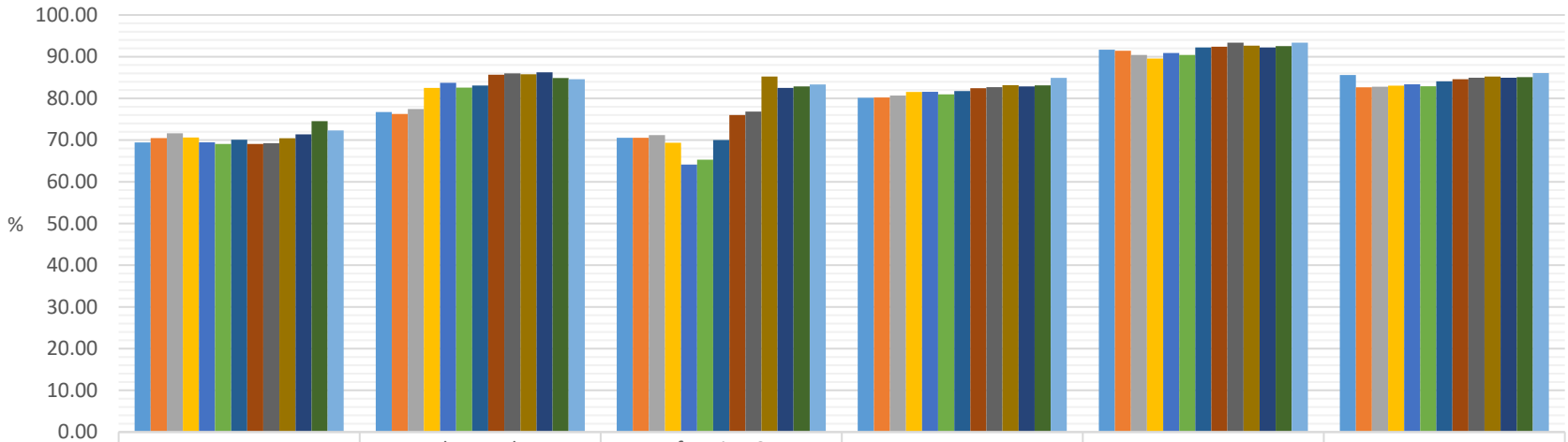
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Corporate	45.76	47.46	39.82	41.74	43.44	45.00	49.58	47.01	48.33	50.43	45.69	46.58	44.59
Research, Development & Innovation	77.27	75.00	42.22	34.04	58.33	60.00	64.58	62.50	61.70	65.96	66.67	72.09	90.91
Transforming Cancer Services	50.00	37.50	40.00	64.29	60.00	66.67	68.75	71.43	66.67	60.00	56.25	43.75	62.50
Velindre Cancer Centre	74.23	76.98	78.68	77.53	79.78	81.07	78.88	76.52	74.31	75.17	76.40	73.77	70.90
Welsh Blood Service	69.32	66.18	67.97	73.19	77.25	78.65	82.41	81.74	79.78	78.27	77.93	77.52	82.19
Velindre Organisations	69.89	70.32	70.19	71.32	74.64	76.07	76.77	75.09	73.28	73.58	73.67	71.69	72.11
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

Sickness Data – The Figures



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Corporate	5.18	5.20	5.24	5.14	4.85	4.59	4.51	4.44	4.33	4.13	4.15	4.13	4.29
Research, Development & Innovation	4.62	4.60	4.37	4.23	4.01	3.73	3.46	3.16	3.34	3.55	3.95	4.30	4.44
Transforming Cancer Services	2.24	2.46	2.41	2.41	2.01	1.34	0.88	0.41	0.32	0.33	0.40	0.86	1.24
Velindre Cancer Centre	5.76	5.88	5.88	5.97	5.77	5.40	5.38	5.41	5.47	5.47	5.51	5.56	5.60
Welsh Blood Service	4.43	4.43	4.44	4.38	4.24	4.19	4.36	4.57	4.81	5.10	5.41	5.69	5.95
Velindre Organisations	5.21	5.28	5.28	5.29	5.10	4.84	4.85	4.91	5.01	5.09	5.23	5.36	5.48
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54

Statutory and Mandatory Figures – The Figures



	Corporate	Research, Development & Innovation	Transforming Cancer Services	Velindre Cancer Centre	Welsh Blood Service	Velindre Organisations
Nov-20	69.45	76.73	70.56	80.13	91.67	85.59
Dec-20	70.47	76.25	70.56	80.23	91.42	82.66
Jan-21	71.61	77.45	71.18	80.69	90.43	82.81
Feb-21	70.62	82.50	69.38	81.53	89.54	83.06
Mar-21	69.47	83.73	64.12	81.57	90.90	83.39
Apr-21	69.06	82.59	65.29	80.98	90.43	82.92
May-21	70.08	83.08	70.00	81.77	92.23	84.09
Jun-21	69.08	85.69	76.00	82.45	92.39	84.59
Jul-21	69.26	86.00	76.84	82.70	93.38	84.97
Aug-21	70.45	85.80	85.26	83.16	92.66	85.24
Sep-21	71.36	86.25	82.50	82.89	92.21	84.95
Oct-21	74.54	84.89	82.86	83.11	92.54	85.10
Nov-21	72.32	84.58	83.33	84.91	93.36	86.06

Job Planning Figures – VCC & WBS combined

Combined

Role	Assignments	With Expired Plan	% With Expired Plan	With Unsigned Plan	% With Unsigned Plan	With Current Plan	% With Current Plan
Consultant	63	37	58.73%	11	17.46%	15	23.81%
Medical Director	2	0	0.00%	0	0.00%	2	100.00%
Specialty Doctor	12	11	91.67%	0	0.00%	1	8.33%
Grand Total	**77**	**48**	**62.34%**	**11**	**14.29%**	**18**	**23.38%**

VCC

Role	Assignments	With Expired Plan	% With Expired Plan	With Unsigned Plan	% With Unsigned Plan	With Current Plan	% With Current Plan
Consultant	60	36	60.00%	11	18.33%	13	21.67%
Medical Director	1	0	0.00%	0	0.00%	1	100.00%
Specialty Doctor	11	11	100.00%	0	0.00%	0	0.00%
Grand Total	**72**	**47**	**65.28%**	**11**	**15.28%**	**14**	**19.44%**

WBS

Role	Assignments	With Expired Plan	% With Expired Plan	With Unsigned Plan	% With Unsigned Plan	With Current Plan	% With Current Plan
Consultant	3	1	33.33%	0	0.00%	2	66.67%
Medical Director	1	0	0.00%	0	0.00%	1	100.00%
Specialty Doctor	1	0	0.00%	0	0.00%	1	100.00%
Grand Total	**5**	**1**	**20.00%**	**0**	**0.00%**	**4**	**80.00%**

NB

Data on the job plans associated with other 'medical' posts within the Trust have not been included in the above; this is due to the relatively small numbers involved and therefore the immediately identifiable nature of this information.

WBS

To continue to maintain compliance across WBS

VCC

ESR imputing issues from Pall/Care and Medical directorate raised with ESR Central team

Work In Confidence (WIC)

No detail has been provided this month in terms of the number of staff who have accessed the WIC platform, or categorisation of the type of conversations that have taken place; this is primarily the result of low usage of the platform over the last month and therefore the potential to identify those who have made contact.

In all contacts with staff, staff are encouraged, where appropriate, to share their concerns with their Line Manager (or next appropriate Manager), in order to achieve an early, informal resolution. The WOD Team have also been previously involved in facilitating discussions between the Manager and member of staff.

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 30TH NOVEMBER 2021 (M8)

DATE OF MEETING	27th January 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Matthew Bunce, Executive Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
N/A		

ACRONYMS	
IMTP	Integrated Medium-Term Plan
WBS	Welsh Blood Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WG	Welsh Government
VCC	Velindre Cancer Centre

1. SITUATION/BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of November 2021.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £000	Year to date £000	Year End Forecast £000
Revenue	Variance	(5)	3	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	454	2,964	10,584
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.3%	95.2%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget continues to remain broadly in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven.

The overall position against the profiled revenue budget to the end of November is an underspend of **£3k**, with an underachievement against income offset by an underspend within Pay.

A large element of the underachievement on planned income relates to WBS WTAIL and Blood Components due to the impact of Covid above the level of forecast reduced income which the Trust is receiving WG funding to cover.

Cost pressures which have / will surface during the year, in line with normal budgetary control procedures, are managed by budget holders to ensure the delegated expenditure control limits are not exceeded.

The Trust is currently planning to fully achieve the savings target during 2021-22. There remain £200k of schemes relating to post Covid savings that are RAG rated as amber. These savings have been replaced with non-recurrent vacancy factor savings as the targets will not be achieved this year whilst still in the pandemic as the cost reductions are offset against the additional costs of Covid as required by WG for Covid funding.

Any slippage or non-delivery against savings targets will be managed through implementation of alternative savings / cost avoidance measures, which may be non-recurrent in nature such as additional vacancy factor.

The Trust is yet to receive a formal funding letter for the remaining balance of Covid requirement, however finance colleagues in WG have provided written assurance that the Trust will be fully funded for Covid related expenditure during 2021-22.

The Trust is therefore reporting a year end forecast breakeven position on the assumption that the savings target for the year is achieved.

2.3 PSPP Performance

PSSP performance for the whole Trust is currently 95.6% against a target of 95%, however the performance against the Core Trust excluding NWSSP is presently falling just short of the target at 94.9%.

PSPP compliance levels have significantly recovered following a temporary dip in performance. Finance colleagues working alongside NWSSP are confident that the 95% target will be achieved this financial year.

2.4 Covid Expenditure

Covid-19 Revenue Spend/ Funding				
	YTD Actual £000	Plan 2021/22 £000	Funding Recevied / Allocated £000	Balance Remaining £000
Mass & Booster Covid Vaccination	278	392	213	179
Cleaning Standards	538	774	367	407
PPE	140	277	147	130
Covid Recovery	1,331	3,222	3,479	(257)
Other Covid Related Spend & Cost Reduction	979	1,475	1,176	299
BFWD Savings Loss	467	700	700	0
Return of Bonus Payment (over allocated)	(83)	(83)	(83)	0
Total Covid Spend /Funding Requirement 2021/22	**3,650**	**6,757**	**5,999**	**758**

The overall gross funding requirement related to Covid is £6,757k which includes £6,140k of directly associated expenditure or cost reduction, £700k in relation to the non-achievement of savings carried forward from 2020/21, and the return of surplus NHS bonus payment £(83)k.

The Trust has received e-mail confirmation from the WG Interim Director of Finance Health and Social Services Group that all the Trust Covid related expenditure identified in table above will be funded.

2.5 Reserves

The financial strategy for 2021-22 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of 522k.

2.5.1 Recurrent Reserves (budget unallocated):

Summary of Total Reserves Remaining Available in 2021/22	£k
Recurrent Reserve Available 2021/22	617
Further Exec Commitment 2021-22	(144)
Remaining Balance	**473**

The current balance of the recurrent reserves for 2021/22 after investment decisions were made at EMB on 22nd November is £473k, **however this funding has now been committed into future years so is only available for non-recurrent investment during 2021/22.**

2.5.2 Non-Recurrent Reserves (budget unallocated):

Summary of Total Non-Recurrent Reserves Remaining Available in 2021/22	£k
Anticipated slippage on NR Allocated reserves	450
Emergency Reserve	522
Remaining Balance	**972**

The Emergency reserve of £522k is set every year and used non-recurrently to deal with any in year unforeseen unavoidable cost pressures. To date none of the Emergency reserves have been utilized.

In addition to the recurrent and emergency reserves, the Executive Management Board (EMB) agreed to make available £1,545k of non-recurrent funding for investment during 2021/22 from the release of accountancy gains. The current spend to November '21 is £584k (includes £87k of new commitments) with a further £511k spend forecast for Dec '21 – Mar '22, taking the total forecast spend to £1,095k. The anticipated slippage against the £1.545k is currently expected to be circa £450k due to delays in implementation of several of the investments which are mainly fixed term posts. This balance is under constant review with potential further slippage. EMB has agreed that non-recurrent funding of £450k will be re-provided in 2022/23 to enable all the approved investments to be fully implemented, provided it can be demonstrated that recruitment of posts or procurement has commenced by the end of December '21.

The non-recurrent reserves still available to invest and cover new unavoidable cost pressures is £972k. **It is important that the Executive Team consider what plans can be implemented in 2021-22 to utilise this available non-recurrent funding to support the significant service challenges in 2022-23.**

2.6 Financial Risks

All new operational financial risks are expected to be managed or mitigated at divisional level. Where this is not possible, or the risk is Trust wide and can not be mitigated the Emergency Reserves will be utilised.

2.7 Capital

a) All Wales Programme

The Trust previously received confirmation of £675k funding from WG towards Capital related Covid recovery. This will be used to support additional donor chairs in WBS, urgent ventilation work, and increased capacity in VCC such as improvements to the outpatient area and Bobarth building which now forms part of the CEL.

In addition, following a communication from WG of the availability of additional end of year capital monies, the Trust was successful in receiving £838k of funding against the £1,396k of schemes it submitted. The request was based on prioritised divisional bids of clinical

equipment in VCC, equipment to establish a component development Laboratory in WBS, and several Digital / IT refresh & infrastructure requirements. Performance against the current agreed All Wales Programme budget allocations are at this stage expected to deliver to budget.

Other Major Schemes in development that will be considered during the remainder of 2021/22 and in 2022/23 in conjunction with WG include, Integrated Radiotherapy Solution (IRS), WBS HQ, VCC Ventilation & Infrastructure/ Outpatients, and WBS Plasma fractionation (for medicines).

The net capital overspend in the TCS Programme will be managed within the overall Programme budget and from slippage / contingency within the Trust discretionary programme.

b) Discretionary Programme

Due to supply chain issues, we are starting to see an emergence of slippage against some of the discretionary schemes that were previously approved. This was discussed at the internal Capital Planning Meeting on the 18th October where other organisational priorities were discussed and agreed to replace the schemes that were would not be fully delivered during 2021/22.

The year-end forecast outturn is currently expected to be managed to a breakeven position, with any further slippage being managed through the Capital Planning and Delivery Group.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:

EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust financial position at the end of November 2021 is an underspend of £3k with a year-end forecast break-even position in accordance with the approved IMTP

4. RECOMMENDATION

4.1 The Trust Board is asked to **NOTE** the contents of the November 2021 financial report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even.

Canolfan Ganser Felindre
Velindre Cancer Centre

GIG CYMRU NHS WALES
Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED NOVEMBER 2021/22

TRUST BOARD
27/01/2022

1. Introduction

The purpose of this report is to outline the financial position and performance for the year to date, performance against financial savings targets, highlights the financial risks, and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2021-22.

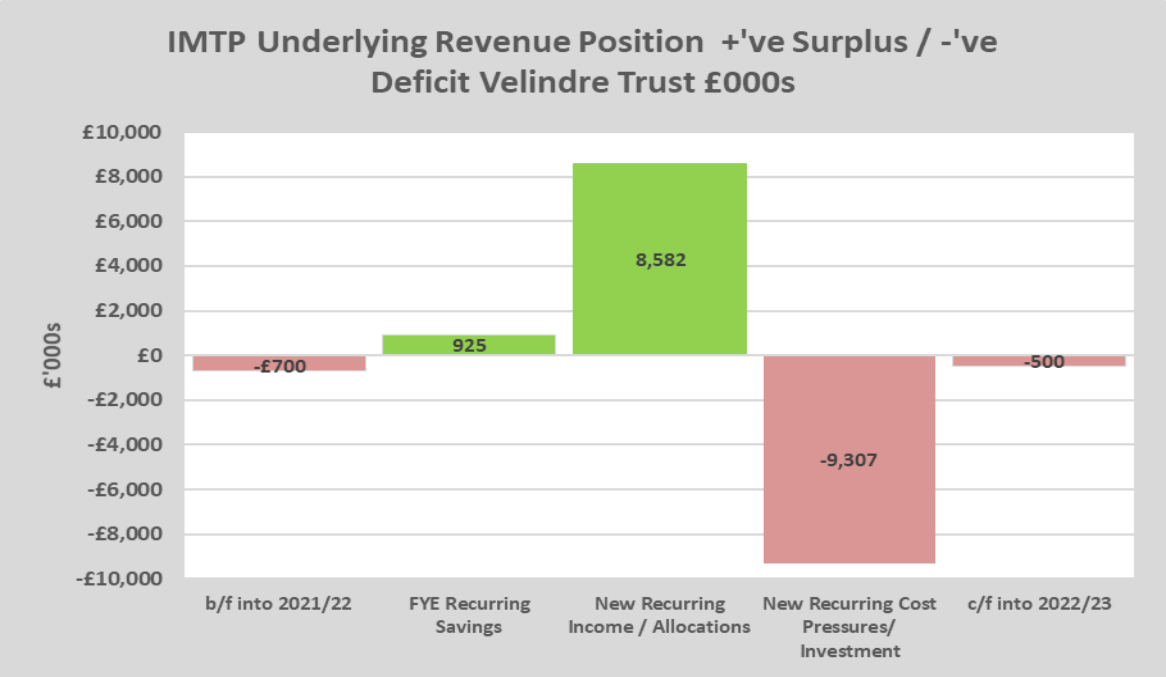
2. Background / Context

The Trust Financial Plan for 2021-22 was set within the following context.

- The Trust submitted a balanced one-year financial plan, covering the period 2021-22 to Welsh Government on the 30 June 2021.

- For 2021-22 the Plan (excl Covid) included;
  - an underlying **deficit of -£700k brought forward from 2020-21,**
  - FYE **of new cost pressures / Investment** of **-£9,307k,**
  - offset by **new recurring Income** of **£8,582k,**
  - and Recurring FYE **savings schemes** of **£925k.**

- Due to the ongoing pandemic and the inability to fully enact savings schemes & cost reduction, the Trust is not expecting to be able to fully eliminate the underlying deficit during 2021-22, however in line with the submitted financial plan the Trust will be aiming to reduce the deficit by £200k to carry forward an underlying position of £500k into 2022-23.
- **To reduce the underlying deficit, the savings target set for 2021-22 must be achieved.**



Underlying Position +Deficit/(-Surplus) £000s	b/f into 2021/22	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2022/23
Velindre NHS Trust	- 700	925	8,582	- 9,307	- 500

3. Executive Summary

Summary of Performance against Key Financial Targets (Excluding Hosted Organisations)

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £000	Year to date £000	Year End Forecast £000
Revenue	Variance	(5)	3	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	454	2,964	10,584
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.3%	95.2%	95.0%

Performance against Planned Savings Target

Efficiency Savings	Variance	0	0	0

Revenue

The Trust has reported a **£(5)k** in-month overspend position for November'21, with a cumulative position of **£3k** underspent, and an outturn forecast of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at November 2021 is **£10,584k** for 2021-22. This represents all Wales Capital funding of **£8,673k**, Discretionary funding of **£1,911k.** The Trust reported capital spend to November '21 of £2,964k and is forecasting to remain within its CEL of £10,584k.

PSPP

During November '21 the Trust (core) achieved a compliance level of **97.26%** (October'21: 97.67%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **95.21%** to the end of November, and a Trust position (including hosted) of **95.76%** compared to the target of 95%.

PSPP compliance levels have significantly recovered following a temporary dip in performance. Finance colleagues working alongside NWSSP are confident that the 95% target will be achieved this financial year.

Efficiency / Savings

The Trust is currently planning to fully achieve the savings target during 2021-22. Any slippage or non-delivery against savings targets will be managed through implementation of alternative savings / cost avoidance measures, which may be non-recurrent in nature such as increased vacancy factor. Where non-recurrent savings schemes are implemented this will require additional recurrent savings schemes to be delivered in 2022-23.

4. Revenue Position

Cumulative				Forecast		
£2,571 Underspent				Breakeven		
Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Income	(107,307)	(106,958)	(349)	(163,777)	(163,509)	(269)
Pay	47,895	47,499	397	71,708	71,410	298
Non Pay	59,412	59,457	(45)	92,070	92,099	(29)
Total	0	(3)	3	0	(0)	0

The overall position against the profiled revenue budget to the end of November is an underspend of **£3k**, with an underachievement against income offset by an underspend within both Pay.

The Trust has now received confirmation that all Covid related expenditure it has forecast will be funded by WG.

4.1 Revenue Position Key Issues

Income Key Issues

- Income underachievement to November is **£(349)k** and is largely where activity is lower than planned on Bone Marrow and Plasma Sales in WBS which is resulting in income loss above Covid support, with assessments as to scale and sustainability ongoing.
- The underperformance in WBS is being partly offset within VCC via an increase in VAT savings from providing additional SACT Homecare.

Pay Key Issues

The Trust has reported a cumulative year to date position of **£397k** underspent on Pay and is forecasting an outturn underspend of circa **£298k**.

Expected reduction in current underspend position against forecasted outturn position, is a result of decisions made in VCC to invest in positions that had associated savings placed against the divisional CIP target. Further alignment of staff to non-staff is expected in future months to help reduce the divisional CIP target.

- Allied Health Professionals are experiencing a small overspend to date which is due to the use of agency in both Radiotherapy and Medical Physics. VCC is aiming to recruit on a permanent basis against some of these posts which commenced in September. This is expected to create a saving going forward from the removal of the premium cost for agency, however due to the difficulty being experienced in recruiting into these posts along

with the requirement to cope with the expected surge capacity, the majority of agency staff will be re-directed to support Covid recovery which is being funded by WG.

- Medical costs have increased due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled and to provide additional resilience against pressured consultants. In addition, enhanced out of hours service, for advanced life support which will be nursing led is currently being covered by Jnr Dr's.
- Each Division of the Trust holds a savings and vacancy factor target which is delivered in year via establishment control. Any forecast adverse variance against the target will be offset through various underspends across numerous staff groups. Largest underspends are currently being experienced in both Admin & Clerical and Nursing due to the high level of vacancies being carried.

Non Pay Key Issues

The Trust has reported a cumulative year to date position of **£(45)k** overspend on Non-Pay and is forecasting an outturn overspend of circa **£(29)k**.

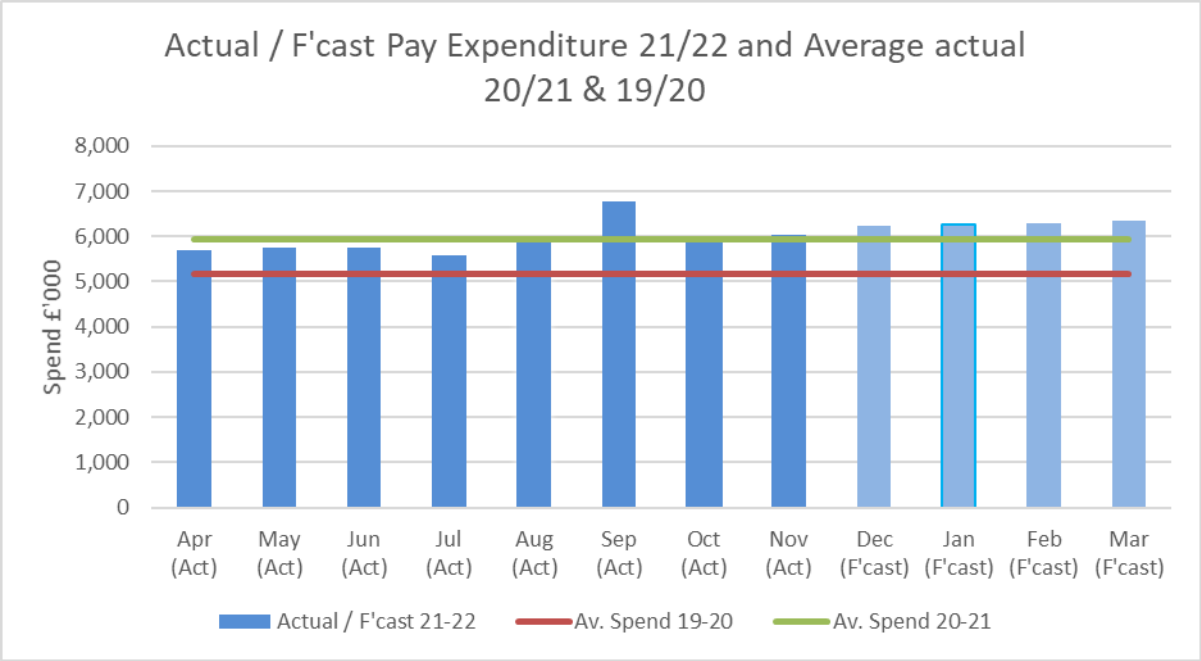
- Large underspend in WBS due to reduced costs from suppressed activity, underspend on Collections Services, Laboratory Services, WTAIL, and General Services
- There are underspends on general drugs in VCC from reduced activity and temporary closure of outreach clinics,
- Facilities Management, along with Maintenance & Repairs are under review in WBS with Trust Estates following increased compliance requirements against new contracts which is pushing the outturn into a forecast overspend position.
- Transport underspend is due to non-recurring fuel savings and consequently maintenance costs relating to the fleet following reduction of vehicle use related to Covid.
- Starting to experience additional Travel & Subsistence costs in relation to increased travel of WBS collections team to clinic which is starting to offset general staff Travel & subsistence
- Printing / Stationary & Postage is underspending due to a reduction in office-based activity and paper-based communications given the increased homeworking. A proportion of this underspend is anticipated to be permanent and will be taken as recurrent saving once the Trust has agreed the operating model of future working arrangements.
- General Reserves / Savings Target relates to the Cost improvement Plan (CIP) targets that are held centrally within divisions. These CIP's will be achieved through the underspends in several areas of non-pay. Additionally, as noted above further alignment of staff underspends to the CIP should result in an underspend within non-staff.
- The Trust reserves and investment funding is held in month 12 and will be released into the position to match spend as it occurs.

Further details on performance against Income, Pay and Non-Pay is provided within the Divisional analysis later in the paper.

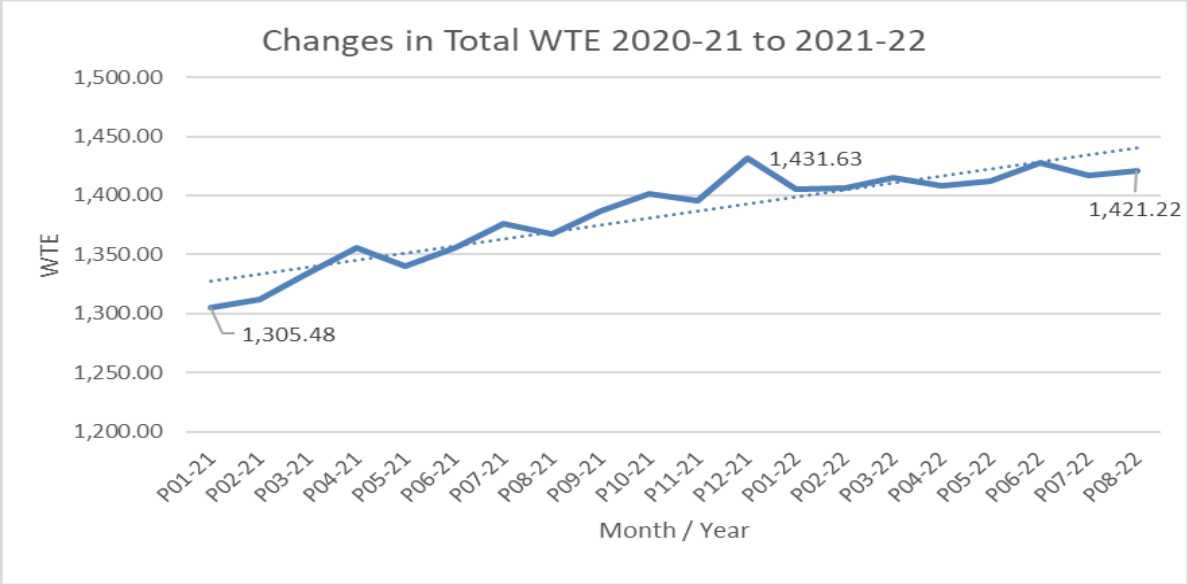
4.2 Pay Spend Trends (Run Rate)

The pay spend for 2020/21 was 14.82% above av. pay in 2019-20. 3% was accounted for by the pay award, 1.14% can be accounted for by an increase in use of agency, 2.3% related to the NHS Bonus Payment with the remaining being the additional staff recruited over the course of 2020/21 (c. 126 wte), and the pay costs associated with Covid.

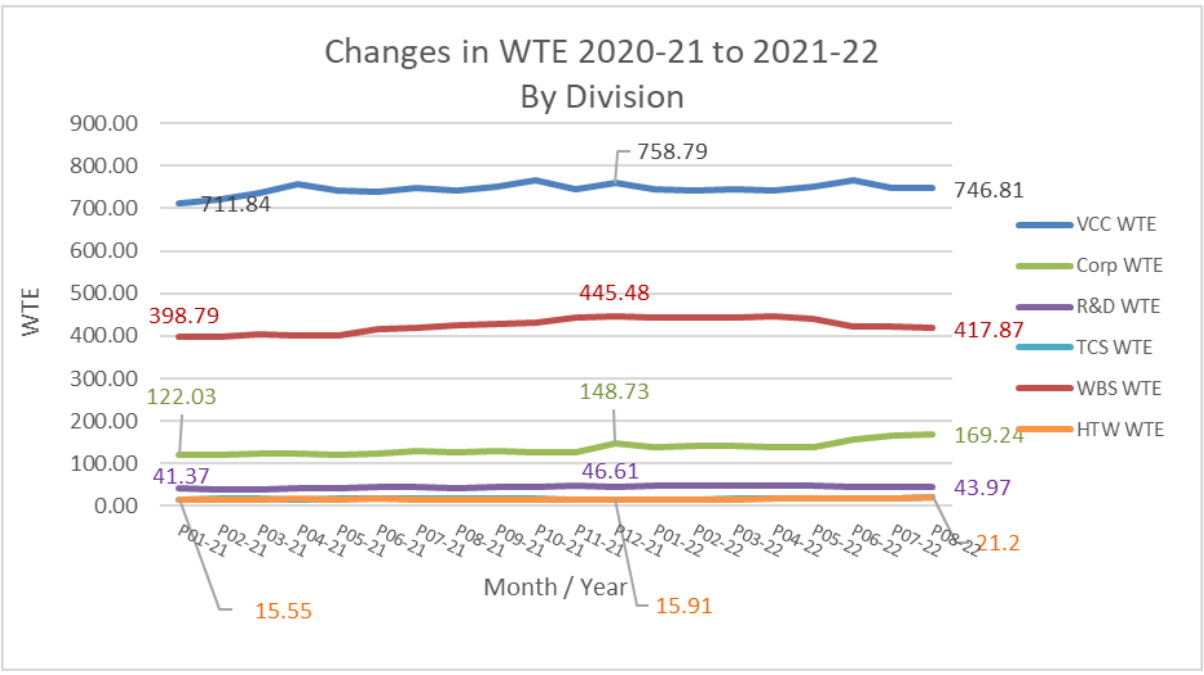
Staff received the 2021/22 pay award of 3% and arrears dated back to April 2021 in their September pay. Excluding the Pay award, spend is still expected to increase with the recruitment of additional posts to meet 'surge' capacity in both VCC and WBS in response to Covid recovery. Whilst the plan was to reduce agency costs within the Trust Core staffing structure, due to the difficulty being experienced in recruitment, the agency staff replaced with substantive recruits will now be utilised as part of the Covid recovery.



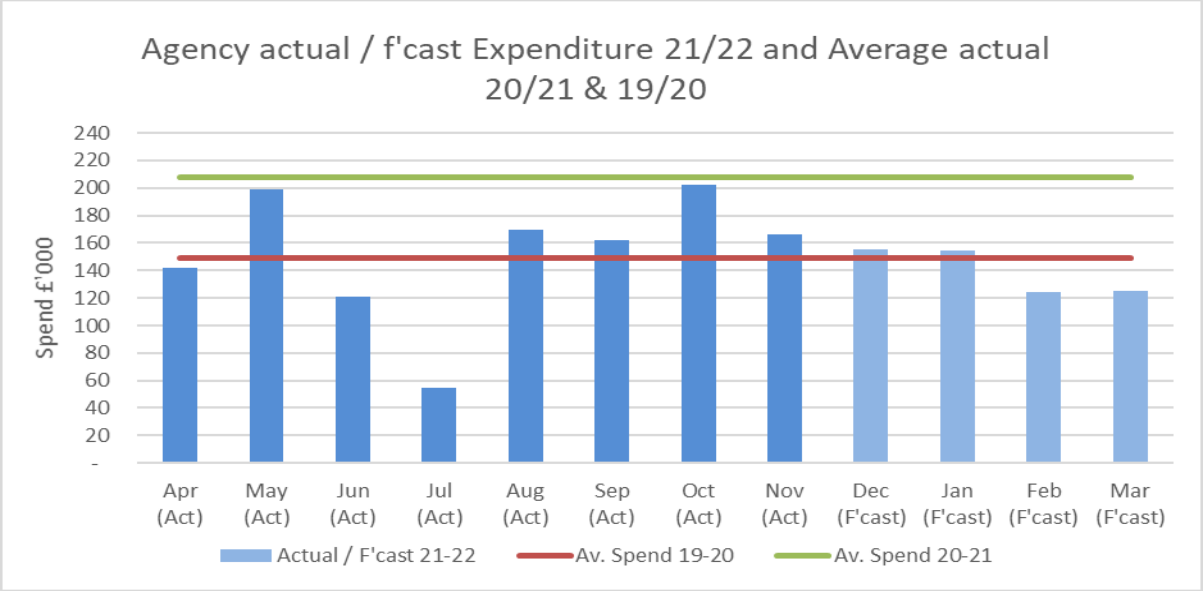
*Sep costs include Pay Award (3%) backdated to April. The perviously reported £2.6m additional pension has been removed as this will be a nominal charge from WG.



*20wte included in period 12 for the Patient Vaccination clinics which have now disbanded. Core Staff increase for 21-22 to October is 10wte.



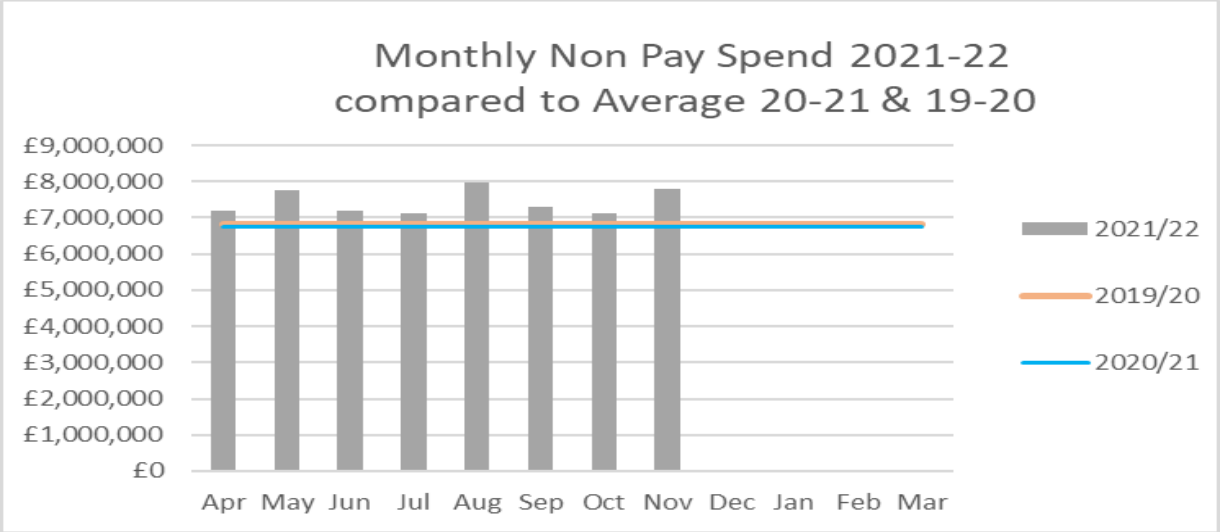
The spend on agency for November was £202k (October £202k), which gives a cumulative year to date spend of **£1,216k** and a forecast outturn spend of circa **£1,776k.** Of these totals the year to date spend on agency directly relating to Covid is £525k and forecast spend is circa £842k.



*The increase in May costs has been reviewed and corrected in July following a full review of agency invoices received against orders raised within VCC.

4.3 Non Pay

Non-pay 20/21 (c£81.2m) av. monthly spend remained static between 19/20 and 20/21 at £6.8m. The average monthly spend for 21-22 is currently £667k (8.98%) more than 20/21, which is largely due to the increase NICE / High-Cost drug usage following the recovery from the impact of Covid.



4.4 Covid-19

Covid-19 Revenue Spend/ Funding				
	YTD Actual £000	Plan 2021/22 £000	Funding Recevied / Allocated £000	Balance Remaining £000
Mass & Booster Covid Vaccination	278	392	213	179
Cleaning Standards	538	774	367	407
PPE	140	277	147	130
Covid Recovery	1,331	3,222	3,479	(257)
Other Covid Related Spend & Cost Reduction	979	1,475	1,176	299
BFWD Savings Loss	467	700	700	0
Return of Bonus Payment (over allocated)	(83)	(83)	(83)	0
Total Covid Spend /Funding Requirement 2021/22	**3,650**	**6,757**	**5,999**	**758**

The Trust has currently received or been allocated funding from WG to the sum of £5,999k, £3,479k towards Covid recovery, £1,903k to cover the first six months of Covid response and £700k to cover the underlying savings loss bfwd from 2020/21. The Trust has returned £83k which was surplus money received toward the NHS bonus payment. This leaves funding to be allocated by WG of £758k.

The Trust is yet to receive a formal funding letter for the remaining balance of Covid requirement, however it has received e-mail confirmation from the WG Interim Director of Finance Health and Social Services Group that all the Trust Covid related expenditure identified in the table above will be funded.

Covid Recovery

The spend and funding requirement to deliver Covid Recovery and Surge Capacity comprises direct outsourcing and enablement of additional clinical sessions within VCC, and an additional collection team within WBS. The resources required will provide coverage for an anticipated surge in capacity of up to 20% above pre-Covid levels for VCC and 10% for WBS, although slippage in the current financial year is already being experienced.

Covid recovery funding has been flexibly managed with Covid response requirements, whilst delivering the capacity intended by the funding. This has maintained the overall funding envelope though recovery has been re-categorised to £3,222k via a reduction in outsourcing to date, but forecast to have a sustained increase in utilisation to the end of the Financial Year.

The Trust has received confirmation that the increase in NICE/ High cost drugs will be funded by commissioners. Latest estimate is circa £2,900k above existing forecast which is based on potential demand should the additional capacity be fully utilised. These figures are excluded from the table above.

Vaccinations

The Trust is expecting to spend circa £392k on the Covid Mass & Booster Vaccination programme during 2021/22. The £392k revenue spend requirement largely relates to the WBS storage and distribution for NHS Wales (£298k), delivery of vaccinations to front line staff in both Velindre and WAST, and the rollout of the Patient Vaccination programme which has now ended (£63k), with the balance being ringfenced for the booster programme which is also drawing to a close (£30k).

WG have provided reassurance that the ongoing Vaccination programme is a priority and that any costs that may be incurred during 2022-23 will be funded.

5. Savings

The Trust established as part of the IMTP a savings requirement of £1,100k for 2021-22, £525k recurrent (£925k full year recurrent) and £575k non-recurrent, with £1,050k being categorised as actual saving schemes and £50k being income generating schemes.

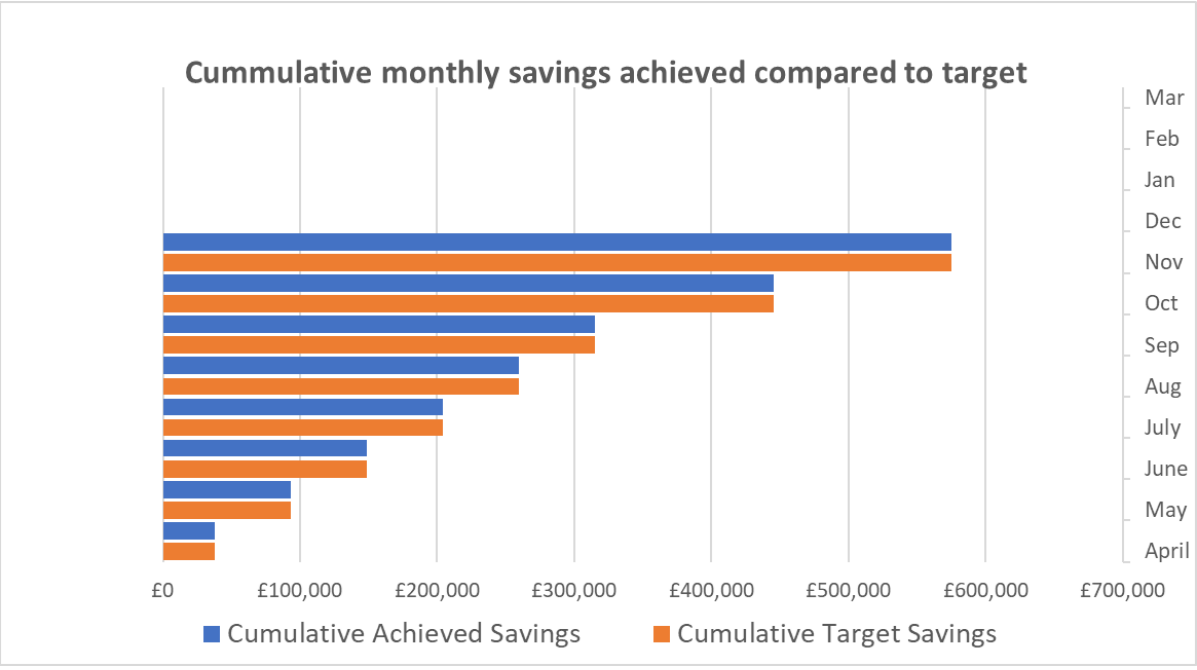
The schemes identified as amber relate to the £200k post Covid savings which have been replaced with non-recurrent vacancy factor savings as the target will not be achieved this year whilst still in the pandemic.

The Divisional share of the overall Trust savings target has been now been re-allocated following the slippage on post Covid savings to VCC £300k (27%), WBS £300k (27%), and Corporate £100k (9%), with £400k (36%) being set at Trust level for combined vacancy factor above the baseline target set by each Division. This was distributed in the September position and included within the divisional savings plans.

Any slippage or non-delivery against savings targets will be managed through implementation of alternative savings / cost avoidance measures, which may be non-recurrent in nature. Any non-recurrent schemes will need to be replaced by additional recurrent savings schemes in 2022-23.

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	Full Year Actual £000	Variance Full Year £000
VCC TOTAL SAVINGS	413	117	117	0	300	(113)
			100%		73%	
WBS TOTAL SAVINGS	368	200	200	0	300	(68)
			100%		82%	
CORPORATE TOTAL SAVINGS	119	67	67	0	100	(19)
			100%		100%	
TRUST TOTAL SAVINGS IDENTIFIED	900	383	383	0	700	(200)
TRUST ADDITIONAL NON-RECURRENT SAVINGS	200	192	192	0	400	200
TRUST TOTAL SAVINGS	1,100	575	575	0	1,100	0
			100%		100%	

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	Variance Full Year £000
Savings Schemes							
Premium of Agency Staffing	Green	150	50	50	0	150	0
Premium of Agency Staffing	Green	100	33	33	0	100	0
Post Covid Savings (VCC)	Red	113	0	0	0	0	(113)
Blood Supply Chain 2020	Green	75	50	50	0	75	0
Blood Supply Chain 2020	Green	25	17	17	0	25	0
Stock Management	Green	200	133	133	0	200	0
Post Covid Savings (WBS)	Red	68	0	0	0	0	(68)
Establishment Control	Green	100	67	67	0	100	0
Post Covid Savings (Corporate)	Red	19	0	0		0	(19)
Total Saving Schemes		**850**	350	350	0	650	(200)
Income Generation							
Maximinsing Income Opportunities	Green	50	33	33	0	50	0
Total Income Generation		**50**	33	33	0	50	0
TRUST ADDITIONAL NON-RECURRENT SAVINGS - VACANY FACTOR		200	192	192	0	400	200
TRUST TOTAL SAVINGS		1,100	575	575	0	1,100	0
				100%		100%	



6. Reserves

The financial strategy for 2021-22 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of 522k.

The current remaining available funding is shown below: -

Summary of Total Reserves Remaining Available in 2021/22	£k
Recurrent Reserve Available 2021/22	617
Further Exec Commitment 2021-22	(144)
Remaining Balance	**473**

The current balance of the recurrent reserves for 2021/22 after investment decisions were made at EMB on 22nd November is £473k, however this funding has now been committed into future years so is only available for non-recurrent investment during 2021/22.

Summary of Total Non-Recurrent Reserves Remaining Available in 2021/22	£k
Anticipated slippage on NR Allocated reserves	450
Emergency Reserve	522
Remaining Balance	**972**

In addition to the recurrent and emergency reserves, the Executive Management Board (EMB) agreed to make available £1,545k of non-recurrent funding for investment during 2021/22 from the release of accountancy gains. The current spend to November '21 is £584k (includes £87k of new commitments). The anticipated slippage against the £1.5m is currently expected to be circa £450k during 2021/22 due to delays in implementation of several investments which are mainly fixed term posts, although this balance is under constant review with potential further slippage. EMB has agreed that non-recurrent funding of £450k will be re-provided in 2022/23 to enable all the approved investments to be fully implemented, provided it can be demonstrated that recruitment of posts or procurement has commenced by the end of December '21.

The non-recurrent reserves still available to invest and cover new unavoidable cost pressures is £972k. It is important that the Executive Team consider what plans can be implemented in 2021-22 to utilise this available non-recurrent funding to support the significant service challenges in 2022-23.

7. End of Year Forecast / Risk Assessment

The Trust is currently reporting a year end breakeven position against its revenue budget, however there are a few risks which are being managed and closely monitored at Divisional level.

8. CAPITAL EXPENDITURE

Administrative Target

- *To ensure that net Capital expenditure does not exceed the Capital Expenditure Limit (CEL) approved by the Welsh Government.*
- *To ensure the Trust does not exceed its External Financing Limit*

	Approved CEL £000s	YTD Spend £000s	Committed Orders Outstanding £000s	Budget Remaining @ M8 £000s	Full Year Actual Spend £000s	Year End Variance £000s
All Wales Capital Programme						
VCC - Transforming Cancer Services	3,711	1,696	0	2,015	3,711	0
VCC Radiotherapy Procurement Solution	312	188	0	124	312	0
IT - WPAS (CANISC replacement phase 2)	993	632	0	361	993	0
Fire Safety	600	140	2	458	600	0
National Programmes - Decarbonisation	109	30	8	71	109	0
National Programmes - Imaging	1,020	0	602	418	1,020	0
Covid Recovery	675	0	0	675	675	0
DHCW - NDR Funding	350	0	0	350	350	0
DHCW - VCC Careflow	60	0	0	60	60	0
HTW Capital	5	5	0	0	5	0
End of Year Capital						
Multileaf Collimator (MLC) Motor Replacements	120	0	0	120	120	0
(CDR) function within the WBS.	83	0	0	83	83	0
Patient Specific Quality Assurance (PSQA) Phantom	100	0	0	100	100	0
Digital IT Client tech refresh	450	0	0	450	450	0
Digital Server Infrastructure Tech refresh	85	0	0	85	85	0
Total All Wales Capital Programme	8,673	2,690	613	5,370	8,673	0
Discretionary Capital	1,911	274	316	1,321	1,911	0
Total	10,584	2,964	929	6,690	10,584	0

The approved 2021/22 Capital Expenditure Limit (CEL) as at November 2021 was £10,584k. This includes All Wales Capital funding of £8,673k, and discretionary funding of £1,911k.

The Trust previously received confirmation of £675k funding from WG towards Capital related Covid recovery. This will be used to support additional donor chairs in WBS, urgent ventilation work, and increased capacity in VCC such as improvements to the outpatient area and Bobarth building which now forms part of the CEL.

In addition, following a communication from WG of the availability of additional end of year capital monies, the Trust was successful in receiving £838k of funding against the £1,396k of schemes it submitted. The request was based on prioritised divisional bids as provided for in the table above.

Performance to date

The actual cumulative expenditure to November 2021 on the All-Wales Capital Programme schemes was £2,690k, this is broken down between spend on the TCS Programme £1,696k, Integrated Radiotherapy Procurement Solution £188k, IT WPAS £632k, Fire Safety £140k, Decarbonisation £30k, and HTW £5k.

The Trust Discretionary funding has now been allocated for 2021-22 and was approved at EMB on the 2nd August. All funds have been committed to schemes other than a contingency being held for emergencies.

Spend to date on Discretionary Capital is currently £274k with a further £316k committed.

Due to supply chain issues we are starting to see an emergence of slippage against some of the discretionary schemes that were previously approved. This was discussed at the internal Capital Planning Meeting on the 18th October where other organisational priorities were discussed and agreed to replace the schemes that were would not be fully delivered during 2021/22.

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position, with any further slippage being managed through the Capital Planning and Delivery Group.

The net capital overspend being reported through the TCS Programme will be managed within the overall Programme budget and from slippage / contingency within the Trust discretionary programme.

Major Schemes in Development

The Trust has also been in discussions with WG over other project funding which it is seeking to secure from the All-Wales Capital programme.

Other Major Schemes in development that will be considered during the remainder of 2021/22 and beyond in conjunction with WG include:

	Scheme	**Scheme Total**	**Stage (i.e., OBC development, FBC development, scoping etc.)**	**21/22**	**22/23**	**23/24**	**24/25**
		£'000		**£'000**	**£'000**	**£'000**	**£'000**
1	VCC Outpatients	800	Feasibility & design study currently being undertaken	0	800	0	0
2	WBS HQ	22,000	PBD approved by WG OBC under development	0	1,000	11,000	10,000

	Scheme	Scheme Total £'000	Stage (i.e., OBC development, FBC development, scoping etc.)	21/22 £'000	22/23 £'000	23/24 £'000	24/25 £'000
3	Ventilation	2,490	BJC to be submitted	0	2,490	0	0
4	IRS	38,429	OBC & PBC approved by WG, FBC under development	0	9,922	7,048	21,459
5	Plasma Fractionation	TBC	Feasibility study to be developed	TBC	TBC	TBC	TBC

9. BALANCE SHEET (Including Hosted Organisations)

The Balance Sheet in NHS Financial Statements is known as the Statement of Financial Position (SoFP). It provides a snapshot of the Trust's financial position including the hosted divisions at a point in time.

The statement shows the Trust's assets and liabilities. As part of the Trust SFIs there is a mandatory requirement to report movement in working capital.

The Trust has now formally removed DHCW from the Trust SoFP, following the transfer of assets and liabilities that took place on the 30 November.

Non-Current Assets

The balance on PPE and intangible assets will move up and down depended on the agreed purchases from the Trust Capital programme (including hosted), offset against the depreciation charges on owned assets.

Trade debtors and receivables will move up and down each month depending on timing of when invoices are raised and consequently paid by organisations.

Current Assets

NWSSP continues to hold high levels of stock in response to Covid which will be passed out to the HB's. In addition, the Trust is still holding £7,000k of contingency stock from 2018-19 which WG asked both NWSSP and WBS to purchase in preparation for Brexit.

The Trust was intending to unwind the contingency stock during 2021-22 and repay the £7,000k cash provided by WG to purchase the Brexit stock, however given the uncertain situation around supply chains which has arisen due to Covid the Trust is currently continuing to hold this stock.

The balance on receivables will move up and down each month depending on the timing of when invoices are raised, and when the cash is physically received from debtors. The Trust actively chases its debts to ensure prompt payment.

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels are fluctuating significantly on a daily / weekly basis. Cash levels are being continually monitored using a cash flow forecast to maintain appropriate levels.

Current Liabilities & Non-Current Liabilities

Liabilities will move up and down each month depending on timing of when commitments are made, and invoices are received and paid.

Taxpayers Equity

The movement on PDC relates to the transfer of Capital assets relating to DHCW.

	Opening Balance Beginning of Apr 20	Closing Balance End of Nov-21	Movement from 1st April Nov-21	Forecast Closing Balance End of Mar 21
Non-Current Assets	**£'000**	**£'000**	**£'000**	**£'000**
Property, plant and equipment	136,558	124,700	(11,858)	124,700
Intangible assets	20,821	5,481	(15,340)	5,481
Trade and other receivables	817,142	1,100,574	283,432	1,100,574
Other financial assets	0	0	0	0
Non-Current Assets sub total	974,521	1,230,755	256,234	1,230,755
Current Assets				
Inventories	95,564	85,187	(10,377)	85,187
Trade and other receivables	548,836	110,156	(438,680)	161,637
Other financial assets	0	0	0	0
Cash and cash equivalents	43,263	69,999	26,736	18,518
Non-current assets classified as held for sale	0	0	0	0
Current Assets sub total	687,663	265,342	(422,321)	265,342
TOTAL ASSETS	1,662,184	1,496,097	(166,087)	1,496,097
Current Liabilities				
Trade and other payables	(353,136)	(212,743)	140,393	(212,743)
Borrowings	(8)	0	8	0
Other financial liabilities	0	0	0	0
Provisions	(316,959)	(316,374)	585	(316,374)
Current Liabilities sub total	(670,103)	(529,117)	140,986	(529,117)
NET ASSETS LESS CURRENT LIABILITIES	992,081	966,980	(25,101)	966,980
Non-Current Liabilities				
Trade and other payables	(7,301)	(7,000)	301	(7,000)
Borrowings	0	0	0	0
Other financial liabilities	0	0	0	0
Provisions	(818,782)	(818,782)	0	(818,782)
Non-Current Liabilities sub total	(826,083)	(825,782)	301	(825,782)
TOTAL ASSETS EMPLOYED	165,998	141,198	(24,800)	141,198
FINANCED BY: **Taxpayers' Equity**				
General Fund	0	0	0	0
Revaluation reserve	27,978	31,052	3,074	31,052
PDC	122,468	94,597	(27,871)	94,597
Retained earnings	15,552	15,549	(3)	15,549
Other reserve	0	0	0	0
Total Taxpayers' Equity	165,998	141,198	(24,800)	141,198

10. CASH FLOW (Includes Hosted Organisations)

The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of any cash-flow difficulties.

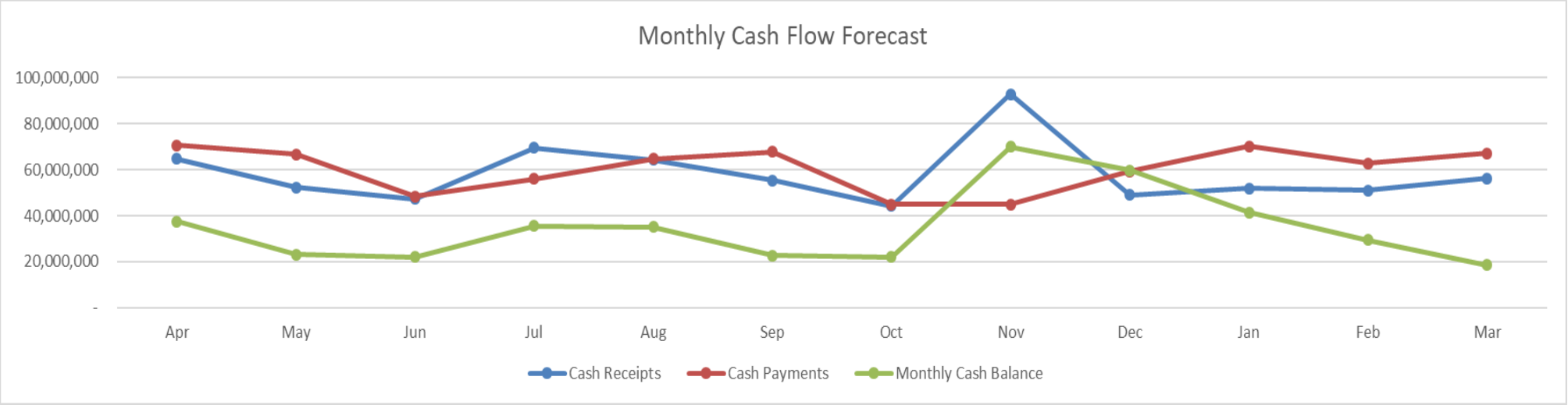
As part of the Brexit emergency planning an additional £5m of stock had been purchased by NWSSP and an additional £2m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019/20. WBS did intend to run down the commercial blood stock, however given the uncertain situation with Covid and potential impact on supply chains the Trust will continue to hold this stock and assess the situation throughout the year. NWSSP are continuing to liaise with WG regarding the level of Brexit stock to maintain but it is anticipated that the repayment of the additional cash will not take place now until at least January 2022.

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels over the past year or so have been significantly higher than usual and may continue to be above average with ongoing need for Covid related purchases. Due to this, the cash balance can fluctuate significantly on a daily / weekly basis.

Cash levels are monitored daily using a detailed cash flow forecast to ensure the Trust has sufficient cash balances to meet anticipated commitments.

		Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Totals £'000
	RECEIPTS													
1	LHB / WHSSC income	23,348	22,492	30,672	34,078	32,225	28,886	33,252	33,603	33,842	35,820	34,002	29,987	372,207
2	WG Income	33,807	26,132	11,582	30,431	27,512	21,398	6,388	56,520	11,842	13,800	14,825	16,832	271,069
3	Short Term Loans													0
4	PDC												7,146	7,146
5	Interest Receivable													0
6	Sale of Assets													0
7	Other	7,643	3,682	4,973	5,006	4,613	5,004	4,673	2,719	3,280	2,243	2,182	2,300	48,318
8	**TOTAL RECEIPTS**	**64,797**	**52,306**	**47,227**	**69,515**	**64,350**	**55,288**	**44,314**	**92,842**	**48,964**	**51,863**	**51,009**	**56,265**	**698,740**
	PAYMENTS													
9	Salaries and Wages	15,189	22,734	22,015	20,181	19,284	24,383	25,582	24,544	25,157	25,145	25,184	26,547	275,944
10	Non pay items	52,989	43,749	25,742	35,377	45,158	42,830	18,755	19,768	32,320	35,275	34,240	35,446	421,650
11	Short Term Loan Repayment										7,000			7,000
12	PDC Repayment													0
14	Capital Payment	2,375	277	540	453	225	623	631	499	1,725	2,893	3,420	5,230	18,891
15	Other items													0
16	**TOTAL PAYMENTS**	**70,552**	**66,760**	**48,297**	**56,011**	**64,667**	**67,836**	**44,968**	**44,811**	**59,202**	**70,313**	**62,844**	**67,223**	**723,484**
17	Net cash inflow/outflow	(5,755)	(14,454)	(1,070)	13,504	(317)	(12,548)	(655)	48,031	(10,238)	(18,450)	(11,835)	(10,958)	
18	Balance b/f	43,263	37,508	23,054	21,984	35,488	35,171	22,623	21,968	69,999	59,761	41,311	29,476	
19	Balance c/f	37,508	23,054	21,984	35,488	35,171	22,623	21,968	69,999	59,761	41,311	29,476	18,518	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Variance £000
VCC	24,002	24,002	0	36,325	36,325	0
RD&I	37	36	0	(365)	(365)	0
WBS	13,350	13,350	0	20,652	20,652	0
Sub-Total Divisions	**37,389**	**37,389**	**0**	**56,612**	**56,612**	**0**
Corporate Services Directorates	6,040	6,040	(0)	8,854	8,854	0
Delegated Budget Position	**43,429**	**43,429**	**0**	**65,466**	**65,466**	**0**
TCS	437	437	(0)	655	655	0
Health Technology Wales	(7)	(8)	0	28	28	0
Trust Position	**43,859**	**43,859**	**0**	**66,149**	**66,149**	**0**

VCC

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Full Year Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**40,084**	**40,298**	**214**	**62,176**	**62,451**	**275**
Expenditure						
Staff	27,010	26,977	33	40,665	40,815	**(150)**
Non Staff	37,076	37,323	(247)	57,835	57,960	**(125)**
Sub Total	**64,087**	**64,300**	**(214)**	**98,500**	**98,775**	**(275)**
Total	**24,002**	**24,002**	0	**36,325**	**36,325**	**0**

VCC Key Issues:

The reported financial position for the Velindre Cancer Centre as at the end of November 2021 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 8 represents an overachievement of **£214k**. This is largely from an increase in VAT savings from providing additional SACT Homecare, a small over achievement against private patient income due to drug performance which is above general private patient performance, along with additional funding for senior medical non-surgical workforce, increased income against the Radiation protection SLA, and HSST income within Physics Management. This is offsetting the divisional savings target and loss of income from closure of gift shop and volunteer's office in response to Covid.

VCC have reported an underspend of **£33k** against staff for November. The division continues to have a high level of vacancies, sickness, and maternity leave predominantly in Nurse Management, Inpatients, Pharmacy and Radiotherapy which is above the divisional vacancy factor target and is offsetting the cost of agency (£859k to end of November) although £454k is directly related to Covid. Inpatients underspend relates to the holding off on recruitment due to reduced bed capacity from social distancing measures. Medical costs have increased due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled, and to provide additional resilience against pressured consultants. In addition, enhanced out of hours service, for advanced life support which will be nursing led is currently being covered by Jnr Dr's.

Non-Staff Expenditure at Month 8 was **£(247)k** overspent. There are underspends on general drugs from reduced activity and temporary closure of outreach clinics, Nuclear medicine warranty savings, along with cost avoidance generated from closure of gift shop and volunteer's office. This is in part offsetting the one off spend on uniforms and consumables in Pharmacy, One Wales cost pressure, and cost from NWSSP for sponsorship of overseas students, along with reporting fees and oncotype in Senior Medical.

WBS

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**14,860**	**14,302**	**(558)**	**20,991**	**20,336**	**(656)**
Expenditure						
Staff	11,332	11,153	179	16,963	16,835	**129**
Non Staff	16,878	16,499	379	24,680	24,153	**527**
Sub Total	**28,210**	**27,652**	**558**	**41,643**	**40,987**	**656**
Total	**13,350**	**13,350**	**0**	**20,652**	**20,652**	**0**

WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of November 2021 was **breakeven** with an outturn forecast position of **breakeven** expected.

Income underachievement to date is **£(558)k**, where activity is lower than planned on Bone Marrow and Plasma Sales, due to freezer breakdown and Covid suppressed activity. Plasma sales recovery to business-as-usual levels following hire of freezers, although delayed further from original expected return date of November 21. Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulting in income loss above Covid support, with assessments as to scale and sustainability ongoing.

Staff reported a year-to-date underspend of **£179k** to November, which is above the division's vacancy factor target. Vacancies remain high at 38 as at end of month 8. Plasma fractionation staffing costs to be supported by division during 2021/22. Component development staffing costs incurred as a divisional cost pressure with no WHSSC funding secured.

Trust approval to appoint a 4th collection team in response to NHS Wales surge capacity and meeting blood demand commenced on 6th September 2021 and continues. Confirmation received that these costs will be met by WG in 2021-22.

Non-Staff underspend of **£379k** is largely due to reduced costs from suppressed activity, underspend on Collections Services, Laboratory Services, WTAIL, and General Services such as building maintenance and MAK business systems, which is offsetting the divisions savings target.

Corporate

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected £000
Income	**942**	**978**	**36**	**1,238**	**1,225**	**(13)**
Expenditure						
Staff	6,457	6,312	145	9,483	9,164	**319**
Non Staff	525	706	(181)	609	915	**(306)**
Sub Total	**6,982**	**7,018**	**(36)**	**10,092**	**10,079**	**13**
Total	**6,040**	**6,040**	**(0)**	**8,854**	**8,854**	**0**

Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of November 2021 was **breakeven**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

Forecast Income underachievement is due to vacancies within fundraising including a period for the Charity Director where the costs were not recharged to the Charity, which is offset by a forecast underspend against the staff in post. Year to date income overachievement relates to income received upfront in IM&T but is expected to be utilised later in the year.

Staff is forecasting an underspend due to vacancies being held, including the Chief Digital Officer and the Deputy Director of finance which will offset the CIP target and other pressures within non-staff.

The forecast Non pay overspend circa **£(306)k** is due to the divisional savings target £(158)k which is expected to be met in year via staff vacancies. Other main cost pressure relates to the estates budget in VCC which is under immense strain due to the increased repair and maintenance costs of the hospital, recently added costs for statutory compliance and increased material costs, along with general inflation. In addition, several departments have little or no non pay budget to allow for unforeseen and unexpected spend.

RD&I

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**1,948**	**1,908**	**(40)**	**3,271**	**3,271**	**0**
Expenditure						
Staff	1,806	1,767	39	2,625	2,625	**0**
Non Staff	179	177	2	281	281	**0**
Sub Total	**1,985**	**1,944**	**41**	**2,906**	**2,906**	**0**
Total	**37**	**36**	**0**	**(365)**	**(365)**	**0**

RD&I Key Issues

The reported financial position for the RD&I Division at the end of November 2021 was **breakeven** with a current forecast outturn position of **breakeven**.

Currently no issues to report.

TCS – (Revenue)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**0**	**0**	**0**	**0**	**0**	**0**
Expenditure						
Staff	346	346	(0)	537	537	**0**
Non Staff	91	91	(0)	118	118	**0**
Sub Total	**437**	**437**	**(0)**	**655**	**655**	**0**
Total	**437**	**437**	**(0)**	**655**	**655**	**0**

TCS Key Issues

The reported financial position for the TCS Programme at the end of November 2021 is a **breakeven** with a forecasted outturn position of **breakeven.** There is a cost pressure of £17k which it is anticipated will be mitigated.

HTW (Hosted Other)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**1,077**	**1,077**	**0**	**1,625**	**1,625**	**0**
Expenditure						
Staff	944	943	0	1,433	1,433	**0**
Non Staff	126	126	0	220	220	**0**
Sub Total	**1,070**	**1,069**	**0**	**1,653**	**1,653**	**0**
Total	**(7)**	**(8)**	**0**	**0**	**28**	**0**

HTW Key Issues

The reported financial position for Health Technology Wales at the end of November 2021 was **breakeven,** with a forecasted outturn position of **breakeven** on the basis that any potential slippage which is starting to emerge will be handed back to WG**.**

TCS PROGRAMME DELIVERY BOARD

TCS PROGRAMME FINANCIAL REPORT FOR 2021-22 NOVEMBER 2021

DATE OF MEETING	15th December 2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mark Ash, Assistant Project Director
PRESENTED BY	Mark Ash, Assistant Project Director
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
N/A		Choose an item.

ACRONYMS	
TCS	Transforming Cancer Services
Trust	Velindre University NHS Trust
PBC	Project Business Case
PMO	Programme Management Office
EW	nVCC Enabling Works
nVCC	New Velindre Cancer Centre
WG	Welsh Government
IRS	Integrated Radiotherapy Solution
SDT	Service Delivery and Transformation

1. PURPOSE

1.1 The purpose of this report is to provide a financial update to the TCS Programme Delivery Board for the financial year 2021-22, outlining spend to date against budget as at Month 08.

2. BACKGROUND

2.1 In January 2015 the Minister for Health and Social Services approved the initial version of the Strategic Outline Programme 'Transforming Cancer Services in South East Wales'. Following the completion of the Key Stage Review in June/July 2015, approval was received from the Minister to proceed to the next stage of the Programme.

2.2 As at March 2021, the Cabinet Secretary for Health, Well-being and Sport, had approved capital and revenue funding for the TCS Programme and associated Projects of £20.710m and £1.678m respectively.

2.3 Included in this approval was funding for the IRS Project (Project 3a). The PBC for this project was endorsed by WG in 2019-20, providing capital funding of £1.110m from July 2019 to December 2022. The provision was £0.250m in 2019-20, £0.548m in 2021-22, and £0.312m in 2021-22.

2.4 In addition to WG funding, NHS Commissioners agreed in December 2018 to provide annual revenue funding towards the TCS Programme. £0.400m was provided in the initial year of 2018-19, with £0.420m annually thereafter.

2.5 Further revenue funding was provided by Trust in 2019-20 and 2020-21 from its own baseline revenue budget. Funding of £0.060m and £0.030m respectively was provided for nVCC Project Delivery (previously provided by WG until March 2019). Another £0.039m (2019-20) and £0.166m (2020-21) was provided to cover the costs of staff secondment from Velindre Cancer Centre.

2.6 The total funding and expenditure for the TCS Programme and associated Projects by the end of March 2021 was £23.923m: £20.710m Capital, £3.213m Revenue.

3. FUNDING

3.1 Funding provision for the financial year 2021-22 is outlined below.

3.2 In August 2021, the Trust Board approved that the nVCC Project provide interim funding of **c£0.350m** to the EW Project. The funding is to support the work packages associated with tree and vegetation clearance (c£0.250m) and site management and security (c£100k). The EW Project will secure this funding from the approval of its FBC in January 2022. The Project(s) financial plans will be updated in November 2021.

3.3 To date no revenue funding has been provided by WG. The Trust has provided revenue funding of **£0.084m**.

Description	Funding	
	Capital	Revenue
Programme Management Office There is no capital funding requirement for the PMO at present Allocation from £0.420m funding provided from Commissioners for 2021-22 to cover direct clinical/management support and Programme Management Allocation from WG 2021-22 revenue pay award funding	**£ nil**	**£0.246m** £0.240m £0.006m
Project 1 – Enabling Works for nVCC Capital funding from WG was provided on 24 March 2021	**£0.250m** £0.250m	**£ nil**
Project 2 – New Velindre Cancer Centre Capital funding from WG was provided on 24 March 2021 The Trust has provided revenue funding for Project Delivery The Trust has provided revenue funding for the Judicial Review	**£3.460m** £3.460m	**£0.096m** £0.026m £0.070m
Project 3a – Radiotherapy Procurement Solution Final 9 months of a 28 month project, running from 1st August 2019 to 31st December 2021, with a funding allocation of £0.312m for 2021-22 from an overall funding allocation of £1.110m Additional funding provided by the Trust for the Project's increased legal and staff costs	**£0.602m** £0.312m £0.290m	**£ nil**
Project 4 – Radiotherapy Satellite Centre The project is led and funded by the hosting organisation, Aneurin Bevan University Health Board; no funding requirement is expected from the Trust for 2021-22	**£ nil**	**£ nil**
Project 5 – SACT and Outreach Funding has been requested for this project however none has been provided to date	**£ nil**	**£ nil**

Description	Funding	
	Capital	Revenue
Project 6 – Service Delivery, Transformation and Transition Allocation from £0.420m funding provided from Commissioners for 2021-22 to cover direct clinical/management support and Programme Management Funding provided from the Trust's core revenue budget towards the costs of the Project Director post and the Project Manager post Allocation from WG 2021-22 revenue pay award funding	**£ nil**	**£0.313m** £0.180m £0.124m £0.009m
Project 7 – VCC Decommissioning No funding requested or provided for this project to date	**£ nil**	**£ nil**
Total funding provided to date	**£4.312m**	**£0.655m**
	£4.967m	

4. FINANCIAL SUMMARY AS AT 30TH NOVEMBER 2021

4.1 The summary financial position for the TCS Programme for the year 2021-22 is outlined below:

- **CAPITAL** spend is **£1.880m** with a forecast outturn of **£4.304m;** and
- **REVENUE** spend is **£0.448m** with a forecast outturn of **£0.654m**

TCS Programme Budget & Spend 2021-22

CAPITAL	Cumulative to Date			Financial Year		
	Budget to Nov-21	Spend to Nov-21	Variance to Nov-21	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	126,088	122,737	3,351	193,000	191,031	1,969
Project 1 - Enabling Works	100,000	141,977	-41,977	100,000	215,979	-115,979
Project 2 - New Velindre Cancer Centre	435,662	445,966	-10,304	1,008,500	819,895	188,605
Project 3a - Radiotherapy Procurement Solution	272,212	242,520	29,692	346,113	347,049	-936
Capital Pay Total	**933,962**	**953,200**	**-19,238**	**1,647,613**	**1,573,954**	**73,659**
NON-PAY						
nVCC Project Delivery	30,820	27,437	3,383	78,500	78,500	0
Project 1 - Enabling Works	117,000	165,983	-48,983	150,000	707,925	-557,925
Project 2 - New Velindre Cancer Centre	676,977	577,523	99,453	2,180,000	1,689,599	490,401
Project 3a - Radiotherapy Procurement Solution	157,168	155,829	1,338	255,728	254,478	1,249
Capital Non-Pay Total	**981,964**	**926,773**	**55,191**	**2,664,228**	**2,730,503**	**-66,275**
CAPITAL TOTAL	**1,915,926**	**1,879,973**	**35,953**	**4,311,840**	**4,304,457**	**7,383**

REVENUE	Cumulative to Date			Financial Year		
	Budget to Nov-21	Spend to Nov-21	Variance to Nov-21	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Programme Management Office	137,790	138,409	-619	224,833	217,879	6,954
Project 6 - Service Change Team	208,422	215,545	-7,123	312,633	320,906	-8,273
Revenue Pay total	**346,212**	**353,954**	**-7,742**	**537,466**	**538,785**	**-1,319**
NON-PAY						
nVCC Project Delivery	19,117	16,167	2,950	26,000	26,000	0
nVCC Judicial Review	70,000	69,600	400	70,000	69,600	400
Programme Management Office	2,141	8,263	-6,122	21,534	19,263	2,271
Project 6 - Service Change Team	0	178	-178	0	266	-266
Revenue Non-Pay Total	**91,258**	**94,207**	**-2,950**	**117,534**	**115,130**	**2,404**
REVENUE TOTAL	**437,470**	**448,161**	**-10,691**	**655,000**	**653,915**	**1,085**

5. FINANCIAL POSITION FOR TCS PROGRAMME AND ASSOCIATED PROJECTS AS AT 30TH NOVEMBER 2021

CAPITAL SPEND

5.1 ***Project 1 Enabling Works -*** There is a cumulative capital spend to date of **£0.308m** against a budget of **£0.217m**, with a forecast spend for the year of **£0.924m** against a budget of **£0.250m**.

Work package	Spend to 30th November 2021 £m	Forecast Annual Spend £m
Pay	**£0.142**	**£0.216**
Third Party Undertakings	£nil	£nil
Technical Advisers	£0.117	£0.147
Works	£0.012	£0.524
Legal Advice	£0.037	£0.037
Enabling Works Reserves	£nil	£nil
Non-pay	**£0.166**	**£0.708**

Total	**£0.308**	**£0.924**

5.2 ***Project 2 - nVCC -*** There is a cumulative capital spend to date of **£1.174m**, against a budget of **£1.270m**. The forecast spend for the years is **£2.779m** against a budget of **£3.460m**.

Work package	Spend to 30th November 2021 £m	Forecast Annual Spend £m
Pay	**£0.569**	**£1.011**
Project Delivery costs	£0.027	£0.079
Competitive Dialogue – PQQ & Dialogue	£0.574	£1.452
Legal Advice	£0.012	£0.053
nVCC Reserves	-£0.009	£0.184
Non-pay	**£0.605**	**£1.768**
Total	**£1.174**	**£2.779**

Project 3a – Integrated Radiotherapy Procurement Solution

5.3 There is a cumulative capital spend to date of **£0.398m** (£0.243m pay, £0.156m non-pay) for the IRS Project against a budget of **£0.429m**. The Project is currently forecasting a spend of **£0.602m** (£0.347m pay, £0.255m non-pay) against a budget of **£0.602m**.

REVENUE SPEND

Programme Management Office

5.4 The PMO spend to date is **£0.147m** (£0.138m pay, £0.008m non-pay) against a budget of **£0.140m**. The Project is forecasting a spend of **£0.237m** (£0.218m pay, £0.019m non-pay) in the financial year 2021-22 against a budget of **£0.246m**.

Projects 1 and 2 Delivery Costs

5.5 There is a revenue project delivery cost to date for the nVCC and Enabling Works Projects of **£0.016m** against a budget of **£0.019m,** with a budget and expected spend for the year of **£0.026m**. This spend relates to costs associated with office costs and project support, such as audit, training and Competitive Dialogue support.

nVCC Judicial Review

5.6 There is a revenue spend to date of **£0.070m** against a budget of the same for the legal advice to deliver the requirements of the judicial review process as the Trust is an interested party. The current budget and forecast spend for the year is **£0.070m**.

Project 6 – Service Delivery, Transformation and Transition (Service Change)

5.7 Service Change spend to date is **£0.216m** against a budget of **£0.208m,** made up of pay costs. The Project is currently forecasting a spend of **£0.321m** for the year against an increased budget of **£0.313m**. The adjusted overspend of £9k remains a financial risk to the outturn position for the Project, which the Project Team are working to mitigate.

6. Financial Risks & Issues

6.1 The forecast overspend £9k (revenue) for the Service Change Project remains a risk to the outturn position for the Programme, however it is anticipated that this be funded through other TCS Programme underspends.

7. CONSIDERATIONS FOR BOARD

7.1 This report is included as an appendix to the Trust Board Finance Report.

8. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Staff and Resources
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	See above.

9. RECOMMENDATION

9.1 The TCS Programme Board are asked to **NOTE** the financial position for the TCS Programme and Associated Projects for 2021-22 as at 30th November 2021.

TRUST BOARD

TRUST RISK REGISTER

DATE OF MEETING	27/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not applicable

PREPARED BY	Lenisha Wright, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

Committee/Group who have received or considered this paper PRIOR TO THIS MEETING		
Committee or Group	DATE	OUTCOME
EMB	04.01.22	N/A
AUDIT COMMITTEE	11.01.22	N/A
QUALITY, SAFETY AND PERFORMANCE COMMITTEE	20.01.22	N/A

ACRONYMS	
VUNHST	Velindre University NHS Trust
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
TCS	Transforming Cancer Services
SLT/SMT	Divisional Senior Leadership Teams / Senior Management Teams
EMB	Executive Management Board
QSPC	Quality, Safety and Performance Committee

1. SITUATION AND BACKGROUND

The purpose of this report is to present Trust Board with information on the status of organisational Risks recorded in the Trust Risk Register, as part of the ongoing management and mitigation of risks. The Trust Risk Register includes risks that meet the Trust Board risk appetite criteria for reporting, which for most risk categories are risks >=12 and risks with an impact of 5.

Risk information for this cover paper includes risks level 20, 16, 15, and 12, and risks with impact of five are highlighted in this cover report, in accordance with the risk appetite levels. To note that no level 25 risks have been recorded in the Trust Risk Register.

As discussed at previous meetings, we want to report on risks that are up to date in as transparent a way as possible. Risks in the Trust Risk Register were drawn in December. However, given the current changing circumstances regarding Covid, an Appendix is including for noting by Trust Board of current assessments of potential risks and issues emerging from Silver and Gold Structures.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Risk Register is received and reviewed at Executive Management Board, other Committees and Trust Board. Risks on the Trust Risk Register presented in this report have been reviewed at Divisional Senior Team meetings on scheduled meeting dates.

Trust Board is requested to note and support the continued work being undertaken on the management of risks in the organisation which includes the ongoing validation, authentication and mitigation of risks. Trust Board is requested to scrutinise data in the risk registers including, risk ratings, review dates and identified controls. Trust Board is requested to note the following work that is currently progressing.

- Implementation of the board approved risk process, risk appetite and risk framework;
- Establishing a new risk process;
- Risk mitigation from version 12 to version 14 of Datix;
- User set up and access to the new system (Vs 14);
- Training for staff.

3. THE TRUST RISK REGISTER

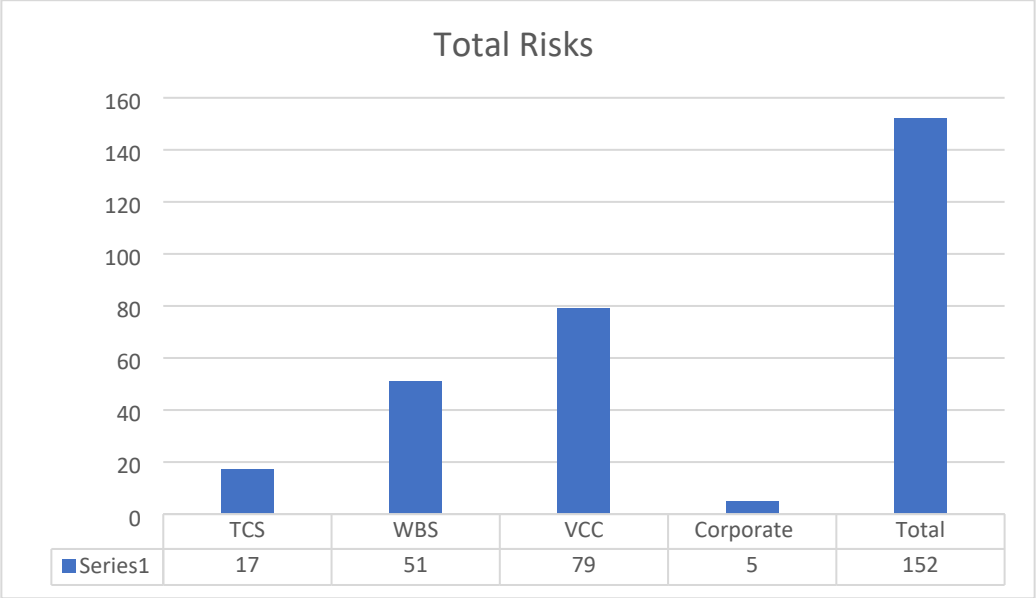
Risks are recorded in two registers currently, version 12 and version 14 of Datix. Trust Risk Registers for Corporate, VCC and TCS are recorded in Vs 14 of Datix, and Risks for WBS is currently recorded in version 12 of Datix. Work is currently progressing with regard to updates on the Risk form in version 14 as well as the development of a paper based Risk form to align requirements ensuring the new process is fit for purpose for all Divisions within the Trust. Following the completion of this process, all risks will be recorded on one risk register, in version 14 of the Datix system.

3.1. Covid Related Risks

The risk profile has changed significantly within weeks in many respects, including: staffing levels; stock levels in WBS; patient isolation guidelines etc. The risk profile extracted from December Datix position prior to Christmas, therefore does not yet reflect many of these fast moving changes. A summary of emerging risks and issues emerging from Silver and Gold structures will be provided in Appendix 3. This will be included in the papers following confirmation through the command structure early w/c 17th January. These risks will then be worked up into the Datix records for February reporting.

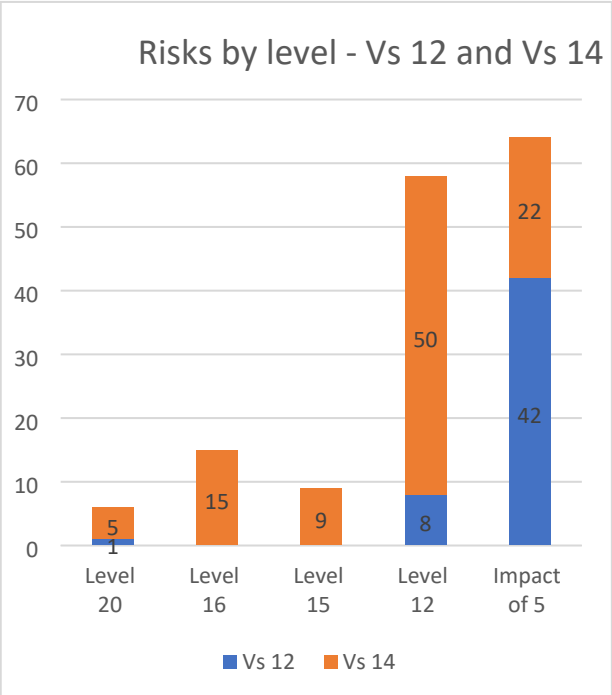
3.2. Total Risks

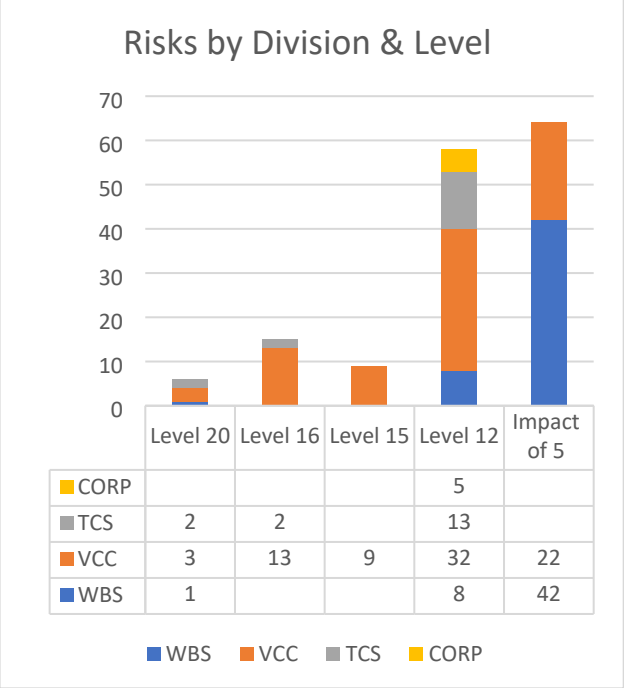
There are a total of **152** risks recorded in Datix Trust Risk Registers, 51 in version 12 and 101 in version 14. This compares to 119 in the November 2021 reporting cycle. The difference is due to risks with an impact of five in version 12 that were not included previously due to technical difficulties which have now been resolved. The graph below provides a breakdown of the total number of risks by Division.



3.3. Risks by level

The graph below provides a breakdown of risks by level across the Trust. A further breakdown of risks by level and Division is also included. Analysis of risks rated 20, 16, 15 and 12 as well as risks with an impact of five are provided under analysis of risks (paragraph 4).





4. Analysis of risks

An analysis of risks by level is provided below. Tables provide detail of each risk including risk type, risk ID, review date and title of the risk.

4.1. Risks level 25

There are no risks with a risk rating of 25 recorded in the Trust Risk Register at the time of the data being extracted from Datix.

4.2. Risks level 20

The table below provides a breakdown of risks level 20. There are currently six risks with a current risk rating of 20 recorded, three for VCC, two for TCS and one for WBS. This compares to five in the November 2021 reporting cycle. Of the six recorded risks with a rating of 20, three relate to performance and service sustainability and three to workforce. Five of these were scored as 20 in the previous reporting cycle (2191, 14764, 2437, 2401 and 2400) with one additional risk has been rescored level 20.

One risk is recorded with an increase in risk score:

- 2200 - has increased from a risk score of 16 reported in the previous period to a score of 20 in this reporting period. The risk relates to resource capacity within radiotherapy and was previously reported as level 16 in the November reporting cycle. The risk score has increased following analysis and assessment. The actions and controls are described as a maximising capacity for radiotherapy document which was written by the Radiotherapy Management Group. The required escalation processes to address capacity challenges is currently underway.

Risk Type	ID	Division	Review date	Title
Performance and Service Sustainability	14764	Welsh Blood Service	06/04/2022	Brexit - Implications of Exiting the EU - No Deal Situation
	2200	Velindre Cancer Centre	31/12/2021	Radiotherapy Capacity
	2191	Velindre Cancer Centre	31/01/2022	Inability to meet COSC / SCP targets
Workforce and OD	2437	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR042(R) - Delay in new Radiographer graduates starting, likely to be October/ November 2021

	2401	Transforming Cancer Services	04/02/2022	Risk of insufficient resources being made available to the Project
	2400	Transforming Cancer Services	31/01/2022	Risk that there is lack of project support

4.3. Risks level 16

The table below provides information of level 16 risks as per the Risk Register. There are currently a total of 15 risks with a current risk rating of 16, two for TCS and 13 for VCC. This compares to 16 in the November 2021 reporting cycle. 15 risks remain scored 16 and one (Risk ID 2200) increased to a score of 20 (see paragraph 4.2).

New Risks: No new risks have been reported with a score of 16 in this reporting period.

Risk Type	ID	Division	Review date	Title
Compliance	2428	Velindre Cancer Centre	29/11/2021	There is a risk of increased infection transmission due to poor ventilation.
Financial Sustainability	2198	Velindre Cancer Centre	13/12/2021	VCC may face financial loss, legal action, inadequate service provision as a result of no coordinated system for SLAs, contracts
Performance and Service Sustainability	2402	Transforming Cancer Services	31/01/2022	Risk of time-consuming infrastructure work
	2190	Velindre Cancer Centre	31/03/2022	BI Support for reporting of Breaches
	2211	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR004(R) - Requirements for Standardisation process redesign & agreed Ways of Working
	2203	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR013(R) - Accelerated Timelines of the DHCR Programme
	2221	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR019(R) - Clinical Coding Copy Functionality within WPAS
	2329	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics

	2328	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR035(R) - SACT & Medicines Management – processes
	2440	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics
	2193	Velindre Cancer Centre	01/04/2022	Medical Physics Expert cover for Molecular Radiotherapy (Nuclear Medicine)
	2196	Velindre Cancer Centre	01/12/2021	Radiotherapy Department -COVID Isolation Impact
	2345	Velindre Cancer Centre	06/12/2021	Radiotherapy Dept - Change to service due continued response to Covid19
	2326	Velindre Cancer Centre	31/12/2021	There is a risk that the Service will be unable to significantly reduce the capacity of clinics over the Digital Health & Care
Quality	2403	Transforming Cancer Services	07/01/2022	Risk that enabling works construction exceeds timescale

4.4. Risks level 15

There are currently nine level 15 risks recorded in the Trust Risk Register. All nine risks for this level are recorded for VCC with six relating to performance and service sustainability, one to safety and two to workforce. To note that eight of these risks have remained scored at 15 from the previous reporting period.

New Risk: One new risk has been recorded in this reporting period:

- 2480 – There is a risk that there may be a shortfall of oncologists. The identified risk is based on census predictions that go up to 2025, and highlight potential impact on services. There are a number of control measures identified including: an increase in training placements; developing new multi-professional ways of working; and actively seeking to recruit.

Closed risks: One risk has been closed in this reporting period:

- 2218 - This risk related to parking space at VCC in the West car park. Extended and dedicated parking has now been provided and the risk eliminated.

Risk Type	ID	Division	Review date	Title
Performance and Service Sustainability	2253	Velindre Cancer Centre	01/05/2022	Availability of CANISC System
	2187	Velindre Cancer Centre	31/12/2021	Radiotherapy Physics Staffing
	2205	Velindre Cancer Centre	31/01/2022	CANISC failure
	2296	Velindre Cancer Centre	29/11/2021	Digital Health & Care Record DHCR010(R) - Data Migration Resource
	2252	Velindre Cancer Centre	01/04/2022	Large number of development projects in Radiotherapy
	2220	Velindre Cancer Centre	31/12/2021	Treatment Planning System End of Life
Safety	2185	Velindre Cancer Centre	31/05/2021	Delination Risk treatment delay (16284)
Workforce and OD	2480	Velindre Cancer Centre	23/12/2021	Current and predicted shortfall of oncologists by 2025
	2217	Velindre Cancer Centre	01/12/2021	Medical Capacity for RT Planning in Job Plans

4.5. Risks Level 12

As per the table below, there are currently a total of 58 risks with a current risk rating of 12, five for Corporate Services, Fourteen for TCS, eight for WBS and thirty two for VCC.

New Risks – Two new risks were opened in the reporting period:

- 2486 – There is a risk that the Section 278 application takes longer than expected to be approved leading to delays in overall construction time. The process has started and is being monitored.

Closed Risks - Four risks have been closed in the reporting period:

- 2227 – The inability to comply with Health Protection (Coronavirus Restriction) (Wales) Regulations 2020. There is continuous implementation of IPC and social distancing measures to ensure all patients are triaged and assessed. Other IPC related risks are recorded and managed (see risk ID 2393 and 2397 in the table below).
- 2234 - Non-compliance to COSHH regulations, which may lead to staff injury or ill health when using chemicals not in the SYPOL system. The Alcumus (SYPOL) system is now in place and the risk has been closed.
- 2414 - There was a risk that application to create public right of way could impact enabling works project's ability to use for a Temporary Construction Access Road (TCAR). Allowance has since been made for handling correctly the newly established public right of way through the railway cutting.
- 2235 - There is a risk at VCC of health and safety breaches due to lack of dedicated H&S support. An H&S audit was undertaken and various improvements in COSHH management and processes have been put in place. Operational Services are supporting the division (VCC) in taking this forward. A number of staff and managers have completed professionally accredited H&S training.
- 16883 – There is a risk that the implementation of Oracle Release R12.2.9 (Phase 1) may affect requisitions for catalogue and non-catalogue items. Participation in several phases/iterations of UAT have helped identify issues/errors in the system. Service point tickets are raised when required for issues/errors identified on an ongoing basis.

4.6 Impact level 5

Risks in the table below include risks with an impact of 5 and a score below 12. These risks are included in accordance with the risk appetite levels. Each of these risks are going through review during this cycle and updates on these risks will be republished in the March cycle of papers, in line with service priorities. As mentioned above, further insight and analysis from SLT for VCC and SMT for WBS will be included in versions of the paper for Board.

There are a total of 64 risks with impact of five, 23 relate to VCC and 41 to WBS. Of the 64 recorded risks, eleven relate to compliance, 42 to performance and service sustainability and eleven to safety.

New Risks: No new risks with impact of five have been recorded in the period.

5. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Is considered to have an impact on quality, safety and patient experience
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Risks open for extended periods of time without indication that work is being undertaken could expose the Trust that may have legal implications.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	If risks aren't managed / mitigated it could have financial implications.

6. RECOMMENDATION

Trust Board is asked to:

- **NOTE** the risks level 20, 16, 15, 12 and impact of 5 reported in the Trust Risk Register and highlighted in this cover paper.
- **NOTE** that a project plan is in place and actions undertaken to expedite progress in establishing a consolidated risk process for the Trust.
- **NOTE** the further work in January to update the profile in light of the recently changing covid risk profile.

- **NOTE** the **APPENDIX**, when received, summarising current assessment of potential risks and issues emerging regarding the current Covid response.

ID	Division	Approval status	RA Date	Title	Description	Controls in place	Current Risk Rating	Review date
16894	Welsh Blood Service	Final approval	28/10/2021	Transfusion associated acute lung injury risk reduction strategy	WBS supply of apheresis platelets from female or previously transfused donors, not screened for HNA antibodies	Donor screening identifies donors that may have experienced sensitising events (previous transfusion/pregnancy) but without HNA antibody screening is not able to mitigate the risk of these antibodies being present.	5	28/01/2022
16900	Welsh Blood Service	Final approval	18/10/2021	Apheresis Premises at Velindre cancer Centre	Velindre Cancer Centre Hospital building	Hospital facilities are inspected by an external contractor (Hurley & Davies). The VCC collection suite has been licenced by the HTA and will be regularly inspected by the WBS. H&S, Fire inspections regularly undertaken.	5	18/10/2022
16883	Welsh Blood Service	Final approval	20/09/2021	Implementation of Oracle Release R12.2.9 (Phase 1)	IPROC module - allows users to order catalogue and non-catalogue for non-stock items from suppliers.	(1) Participation in several phases/iterations of UAT have helped identify issues/errors in the system. Servicepoint tickets were raised when required for issues/errors identified. (2) Smoke testing has been performed by eEnablement which incorporated end-to-end testing.	12	31/12/2021
16809	Welsh Blood Service	Final approval	06/09/2021	Malaria Risk – Delay in Implementation of the Process to Support Amended Malarial Testing for a Specific Donor Group	Non-compliance with donor assessment based on the JPAC Donor Selection Guidelines for donors with MALR, MALF and MALP risks. No malaria discretionary test is undertaken following re-exposure to a malarial risk for donors in this group.	This issue has been fully discussed at JPAC / SACTTI-(Parasites) group. The MHRA have laisied with the Chair of JPAC- the conclusion is that whilst WBS practice is safe, the recommendation is to align WBS practice with other UK Services. By definition all these donors will have tested negative for malaria at their first donation - this part of the process is robust. It is the subsequent testing post re-exposure that is missing.	5	06/09/2022
16762	Welsh Blood Service	Final approval	13/08/2021	Supply Chain disruption of Blood Collection tubes	All other tubes not on the shortage list (10ML, 6ML etc)Update-17/08/2021	"Internal stock take and regular monitoring and management of WBS stock position. Stock holding of 8 weeks supply at present. Stock projection received from BD for coming months and identification of WBS allocation."	10	18/03/2022
16703	Welsh Blood Service	Final approval	23/06/2021	Risks identified for implementation of Oracle R12.2.9	Lack of end to end testing	None	12	17/12/2021
16780	Welsh Blood Service	Final approval	22/04/2021	Transport of Donor Records to and From WBMDR Collection Centre	Transport of paperwork that may contain donor personal identifiable information (PII)	Paperwork transported by WBMDR staff is kept to the minimum required (note: all WBMDR documentation only contains the minimum required PII to facilitate the collection). Staff are aware of the GDPR requirements, and have received training in Information Governance. Information and training provided by the WBMDR and stated in the standard operating procedure for the stem cell/PBL collection (SOP HUB-903). Staff advised to drive directly between the WBS and the collection centre unless absolutely necessary to stop or divert. Paperwork stored together securely (in a closed folder or bag) and out of sight in the vehicle.	5	22/04/2022
16788	Welsh Blood Service	Final approval	16/03/2021	Apheresis Premises at Nuffield The Vale Hospital	Nuffield the Vale Hospital building	Hospital is HIW inspected, HTA licenced and inspected by the WBS. H&S, Fire and HIW inspections regularly undertaken.	5	16/03/2023
16398	Welsh Blood Service	Final approval	11/12/2020	Review of modules used in Oracle Finance & Procurement System - GxP impact	Purchasing - used to manage the procurement of both stocked items (using the Inventory module), and non-stocked items (using the IPROC module).	Functionality verified in CQ test scripts for IPROC and Inventory (Note: issues would only be identified in the Live environment during CQ testing)	12	23/12/2021
16467	Welsh Blood Service	Final approval	27/11/2020	Receipt, Storage and Distribution of Covid 19 Vaccines	Recording time of vaccine removal from -80 freezer	Labels printed with time Print labels before removal of vaccine from freezer risk treatment - validate printed labels	5	22/10/2022
16295	Welsh Blood Service	Final approval	22/09/2020	Use of Female Plasma for Manufacturing Pooled Cryoprecipitate	WBS Cryoprecipitate made from female donors not tested for HLA/HNA antibodies	"Prevention 2) Low level of plasma from each donor, reducing any potential antibody concentration"	5	12/04/2022

16266	Welsh Blood Service	Final approval	15/09/2020	Inability to secure venues during response /recovery plan for Covid-19 - Impact to Blood Supply Chain	Inability to operate clinics at the same efficiency verses pre-Covid 19 due to social distancing and IPC measures/amount of donors able to attend venue due to social distancing measures.	Escalated to the Director of WBS And Chief Operating Officer for VUNHST, Head of Planning Logistics and Resource to submit SBAR outlining emerging situation and required support. Explored with MOD available venues. Ongoing dialog with PHW and WG about conflict between vaccination and WB venues. Update 28/01/2021 - A number of Health Boards have not yet responded to email , those that have showed that there will be some conflict with venues in certain regions. Working on proof of concept for use of trailers in a socially distanced environment. Also looking at options around a potential fixed site.	12	01/08/2022
15973	Welsh Blood Service	Final approval	19/05/2020	Exposure to Potential Pre-symptomatic, Asymptomatic Individuals at Verification Sample Procurement, Donor Information, Medical A	Donor Exposure to potential pre-symptomatic, asymptomatic individuals at VT sample collection - Performed by a Health Care at Home under contract to the WBMDR.	Assurances received from Health Care at Home that correct protocols are being implemented with regards to social distancing and use of appropriate PPE.	5	06/03/2022
16009	Welsh Blood Service	Final approval	18/05/2020	Social Distancing measures within the Laboratory environment (Lab Services and WTAIL)	See attached FMEA	See attached FMEA. Reviewed FMEA attached. Risk further reduced by staff vaccination program. All other measures remain in place. GS, 27/05/21	5	27/05/2022
15937	Welsh Blood Service	Final approval	04/05/2020	Covid-19 implications of handling biological samples within the WBS	Handling of untested or presumed COVID-19 negative samples for laboratory testing	Appropriate staff training, supervision and competence. Good laboratory practice. Use of standard laboratory PPE including nitrile gloves and labcoats. Risk treatment plan and recommended actions: All staff should be aware that there is the potential for any sample to be positive for COVID-19, as patients or donors may be asymptomatic. If appropriate, all primary samples should be centrifuged and left for at least 10 minutes before decapping to reduce aerosol risk. Centrifuge bucket lids must be used to reduce aerosol production risk in the event of tube breakage. Aerosol-generating or potential splashing procedures should be performed in a Class-2 microbiological safety cabinet if possible and appropriate. If these cannot be performed in a cabinet these procedures must be identified and additional proportionate controls put in place, such as capping of tubes, safety screens or PPE. Local Risk assessment within each laboratory should be performed to identify these procedures. Update 06/01/2021. Vaccination for all front line/lab staff has ben tolled out, Increased UK testing capability, increased use of PPE for all staff. No evidence of laboratory COVID-19 transmission has been seen, and no evidence (either locally or worldwide) that COVID-19 has been transmitted by aerosol from laboratory samples	5	05/10/2022
15932	Welsh Blood Service	Final approval	23/04/2020	Impact of COVID-19 stabilisation phase to WBS	Re-introduction of elective procedures including Haematology activities. WBS are aware that WG have written to all Health Boards regarding the re-introduction of this work.	VUNHST planning team and WBS blood health team are liaising with hospitals to determine future demand. Existing MOU with the UK blood services to support in the event of a shortage in a blood component. WBS planning team have forecasted future collection models based on potential scenarios. Currently working on a proof of concept around trailer use in a socially distanced environment and also considering fixed site options.	12	05/11/2021

15746	Welsh Blood Service	Final approval	18/02/2020	Process Risk Assessment - Environmental Monitoring	Heat Sealers - including Blood Press Sealers	Maintenance regime in place to ensure equipment remains in peak performance at all times.	5	21/12/2021
15533	Welsh Blood Service	Final approval	27/09/2019	Manual Double Entry of Test Results in Automated Testing - Contingency Process	Manual entry of test results which are normally interfaced directly from an analyser into BECS.	Components from a positive donation are physically removed from the supply chain by Automated Testing staff.	5	15/12/2021
15456	Welsh Blood Service	Final approval	11/07/2019	Clinical RA for not providing HbS negative red cells	HbS negative blood not supplied by WBS as recommended by JPAC guidance	"- low incidence of HbS in Welsh population (0.02% in 2013) '- Most HbAS units block leucodepletion filters and don't make it to a usable donation"	5	22/02/2022
15373	Welsh Blood Service	Final approval	27/06/2019	Risks associated with MAK-System introduction of new interfacing policy for devices connected to ePROGESA	Increased complexity of networking / integration architecture in respect of the middleware used to interface devices that require interfacing to MAK-System products (e.g. ePROGESA). Additional costs incurred for establishment and maintenance of interfaces to MAK-System products (e.g. ePROGESA).	Ability to liaise with suppliers during procurement to advise on WBS preferences in respect of middleware arrangements for connected devices. MAK have recently confirmed "non partners" will still be permitted to interface devices to ePROGESA and other related MAK services. Subject to ongoing monitoring and discussion via International MAK-System User Group (IMUG).	12	28/02/2022
15398	Welsh Blood Service	Final approval	06/06/2019	Facilities Infrastructure	Electrical circuitry is not installed to current standards	Not installing any new equipment until power supply has been updated..	10	18/02/2022
15297	Welsh Blood Service	Final approval	29/04/2019	WBS Cyber Security Attack or Breach	WBS Systems and Services	Antivirus software deployed to detect threats. Device control deployed to limit access to removable devices. E-mail messages are scanned for threats and spoofing by NWIS. Web browsing is via a proxy server that scans for viruses and malicious content. Software updates are rolled out to address vulnerabilities in operating systems and key applications. Firewalls are enabled at device level as well as network levels to restrict access from unwanted systems. Newer operating system deployments are harden against security baselines recommended by suppliers and NCSC. Regular backups of critical and key data. Vulnerability scanning conducted against WBS devices. Phishing exercises targeted at WBS users	10	22/04/2022
15261	Welsh Blood Service	Final approval	01/04/2019	Microsoft Windows 7 and Server 2008 R2 End of Support	Windows Server 2008 R2 server operating system (ePROGESA)	Server operating systems are protected by local and network firewalls - this limits which devices can access the servers. Antivirus software provides detection and remediation against known threats. Internet usage and E-Mail is generally blocked from servers. System have been hardened against best practices. General users are only able to access limited parts of the ePROGESA environment, for example, Database Servers are not accessible	10	22/10/2021
15262	Welsh Blood Service	Final approval	01/04/2019	Oracle Java 8 End of Support	Oracle Java Runtime Environment	Java environment has been hardened to limit where applications can be launched from. Client operating systems are protected by local and network firewalls - this limits which devices can access the clients. Antivirus software provides detection and remediation against known threats. Removable media controls limit threats from USB/DVD drives. Internet usage is monitored to protect from web and downloadable threats. E-mail messages are scanned for threats. System have been partially hardened against best practices	5	22/04/2022
15189	Welsh Blood Service	Final approval	22/01/2019	Red Cell Antibody detection on the PK7300	Failure to detect high level anti-D on PK7300 - impact on Apheresis donations - not neonatal	None	5	14/01/2022
14764	Welsh Blood Service	Final approval	09/10/2018	Brexit - Implications of Exiting the EU - No Deal Situation	Increased expenditure	Public Contract Regulations Budgeting and financial controls	20	06/04/2022
14744	Welsh Blood Service	Final approval	03/09/2018	Abbott Microbiology Platform	Result Transfer to eProgesa	WBS Procedures Peer Review	5	13/01/2022

14508	Welsh Blood Service	Final approval	09/07/2018	Management of Work Place Related Stress	Could affect every activity within WBS including collections, processing and distribution etc. of blood products	Policy (Trust wide Mental Health , Wellbeing and Stress Management WF43) Toolkit to support Good Mental Health, Wellbeing and Reduce Stress. Employee assistance programme All Wales Wellbeing Tool Kit Stress risk assessment (completed by manager with staff member) Sickness absence policy Manager Training Mindfulness / complementary therapy Team Assistance Organisation Development facilitated discussion and mediation Organisation change RA Blood Supply 2020 relating to stress. Work life balance - flexible working. Health and wellbeing - Cycle to work scheme to promote healthy activities. Monitoring of sickness and absence reasons and levels. PADR process - clear roles and responsibilities. Manager support. Update Oct 2019 Continue to monitor sickness and absence levels WBS Sickness and Absence Deep Dive Stress Related Absence document produced Dec 2018 Ongoing wellbeing initiatives Initiatives introduced to look at finances - Home finances impact on stress Menopause Policy developed and initiatives to look at this introduced (Menopause Café) which impacts on work place stress	12	01/09/2021
14215	Welsh Blood Service	Final approval	06/03/2018	Risks associated with the implementation of Prometheus into WTAIL	Failure of WTAIL to meet its regulatory obligations (e.g HTA)	URS signed off and agreed. Regular meetings with supplier to ensure URS requirements are fulfilled. Regular communication with supplier in respect of changing/ new regulatory requirements. Development complete. Update 13/10/2020 UAT is complete.	10	01/04/2022
13819	Welsh Blood Service	Final approval	21/02/2018	Blood Supply Chain 2020 Initiative - Impact on Staff	Revised roles and contractual changes. New ways of working.	Early engagement with staff. Full support package available on intranet. Occupational Health support available. Potential for staff opportunities. Involvement of staff in decision making.	12	18/11/2021
13311	Welsh Blood Service	Final approval	08/11/2017	Reprinting Group Labels for overweight imported red cells	Reprint group label for imported red cell which is overweight (outside maximum volume parameter)	"NHSBT & SNBTS have an automatic discard set for components that are overweight/ over-volume (i.e. all Blood Services comply to the Red Book Guidelines and have their processes controlled accordingly). Laboratory staff identify non-conforming donations.	5	12/04/2022
12342	Welsh Blood Service	Final approval	29/03/2017	Use of the External Plasma Freezer	Safety of staff whilst using the freezer	None (PPE)	5	01/11/2022

12104	Welsh Blood Service	Final approval	02/02/2017	Movement of WBS personnel within the service yard area	Staff movement in the service yard .	Designated speed limit of 10 mph within the service yard area. Entrance gate controlled from central point (reception). Entrance gate is kept closed and access to the service yard is via intercom. Adequate lighting located in service yard area. All transport department staff and CCA drivers who use the service yard are provided with a service yard awareness briefing. This is undertaken as part of their training and is detailed in the training booklet prepared by transport department. Donor Services personnel and facilities staff are issued with hi visibility jackets /vests to wear when working on service yard area and this is a compulsory requirement. Transport and Facilities staff provide hi visibility jackets/vests to visitors and these visitors are escorted whilst on the service yard. Additional controls include hi vis paint work, periodic service yard inspections, contractor leaflet read and understood before work commences. CCTV coverage of the service yard.	10	01/10/2021
11522	Welsh Blood Service	Final approval	17/10/2016	Antibody detection by Luminex based technology	Detection of HLA antibodies by Luminex based methods	sample collection requirements are stated in WTAIL user guide. samples are only taken by trained phlebotomists and nursing staff. Acceptance of results based on review of patient history as and when available and take into consideration patient own type. Platelet cases require increment data for review of increment levels to determine further support required. Multiple samples are tested for those patients requiring long term support.	10	29/10/2022
9515	Welsh Blood Service	Final approval	03/07/2015	WBMDR Sterile Tube Welder	Sterility	Documented system at Collection centre (by two individuals) to check docking undertaken correctly (recorded on form WBM-551). Use of standard concession system (SOP 566/HUB) in the event of a dock failure. Routine sterility testing of all HPC products (100% testing)	5	04/11/2022
8719	Welsh Blood Service	Final approval	17/12/2014	GMP-0273 (Premises)	Storage area	Restricted access to authorised staff only. Physical segregation of product from routine blood stocks. Clear identification as HPC product	5	20/11/2022
8706	Welsh Blood Service	Final approval	15/10/2014	GMP-0062 (PBSC Collection)	Collection of product	pre-assessment of veins by 2 different healthcare practitioners. BM collection available as possible back-up	5	09/02/2022
8712	Welsh Blood Service	Final approval	15/10/2014	GMP-0066 (Assess Donor Fitness)	Failure to receive completed report in time for 'Final Clearance'.	None	5	09/02/2022
8717	Welsh Blood Service	Final approval	15/10/2014	GMP-0071 (HPC Storage & Transport)	Storage of PBSC/PBL	Stored in GMP monitored area of WBS. Stored in secure area. Controlled product release.	5	05/11/2022
8713	Welsh Blood Service	Final approval	15/10/2014	GMP-0067 (G-CSF administration)	Incorrect dose.	Prescription calculated according to SOP by consultant with nurse. Dosage actually given is recorded on prescription at time of administration.	5	03/03/2022
8715	Welsh Blood Service	Final approval	15/10/2014	GMP-0069 (Final Release)	Product Inspection	Visual inspection of each bag in accordance with documented procedure. Documentation to allow audit trail. Formal concession system to account for any sterile docking failures. 02/11/2016 No change to control measures required.	5	09/02/2022
8707	Welsh Blood Service	Final approval	15/10/2014	GMP-0063 (PBL Collection)	Collection of product.	IDM Testing and Lifestyle questionnaire performed	5	09/02/2022
8708	Welsh Blood Service	Final approval	15/10/2014	GMP-0064 (Whole blood for immunotherapy)	Donor Fitness for purpose	IDM testing and lifestyle questionnaire	5	26/11/2022

7746	Welsh Blood Service	Final approval	02/04/2014	Liquid Nitrogen supply system for TT1-17.	DATIX 2725 - transferred from paper assessment	Wall mounted oxygen depletion sensors- which are regularly serviced and tested (SOP: 008/FAC), linked to an audible and visible alarm in the area and an alarm on the Environmental monitoring system (EMS). In the event of an alarm staff are instructed to leave room TT1-17 immediately: Calibrated personal oxygen depletion monitors in use; Exhaust ventilation for the room, which alarms on the EMS system if it fails; Two emergency stop buttons, one inside the room, one outside to cut-off liquid nitrogen feeding to cryogenic vessels in the event of an over-fill; Overfill or fan failure will cause nitrogen supply to be stopped by emergency cut-off valves, PPE including eye protection BSEN166 (2002) goggles and full-face safety masks (supplied in area), special blue cryoprotective gloves of various sizes. and Lab coats; Safety rules detailed in POL(S)009, including a “buddy system” outside normal hours; Restriction of access, cleaners instructed not to work in the area unless supervised by WTAIL laboratory staff; Safety Training given to new staff at induction; Staff trained to POL(S)-009, and SOP 001/TTY for working with biological agents; Regular servicing of cryogenic refrigerators, and system pipe work by specialist external contractors; Warning signs; Overfill and low pressure alarms on individual units linked to EMS; On-call staff available to respond to alarms out of hours; Laboratory Safety procedures POL(S)-009 instructions on spillages; COSHH assessment completed; First aid; Management of liquid nitrogen system covered by SOP: TTY/112. Annual insurance inspection, CCTV in yard and alarmed external doors near external tank	5	15/04/2022
7736	Welsh Blood Service	Final approval	31/03/2014	Liquid nitrogen storage and retrieval of frozen cells - room TT1-17	DATIX 3482 - transferred from paper assessment	Wall mounted oxygen depletion sensors- which are regularly serviced and tested (SOP: 008/FAC), linked to an audible and visible alarm in the area and an alarm on the Environmental monitoring system (EMS). In the event of an alarm staff are instructed to leave room TT1-17: Calibrated personal oxygen depletion monitors in use; Exhaust ventilation for the room, which alarms on the EMS system if it fails; Two emergency stop buttons, one inside the room, one outside to cut-off liquid nitrogen feeding to cryogenic vessels in the event of an over-fill; PPE including eye protection BSEN166 (2002) goggles and full-face safety masks (supplied in area), special blue cryoprotective gloves of various sizes. and Lab coats; Safety rules detailed in POL(S)009, including a “buddy system” outside normal hours; Restriction of access, cleaners instructed not to work in the area unless supervised by WTAIL laboratory staff; Safety Training given to new staff at induction; Staff trained to POL(S)-009, and SOP 001/TTY for working with biological agents; Regular servicing of cryogenic refrigerators, and system pipe work by external contractors; Warning signs; Written instructions on safe manual handling displayed on wall; Steps available to aid access to vessels for staff as required; Risk assessment on manual handling carried out by Hu-tech; Laboratory Safety procedures POL(S)-009 instructions on spillages; COSHH assessment completed; First aid; Management of liquid nitrogen system covered by SOP: TTY/112	5	04/02/2022
7137	Welsh Blood Service	Final approval	07/11/2013	Electrophoresis in WTAIL Molecular Genetics - analysis of PCR-SSP reactions by agarose electrophoresis	DATIX 3486 - transferred from paper assessment	SOP: MOL/022 Safety policies POL(S)-009, POL(S)-007 Training PAT testing Visual inspection during cleaning Intact lids prevent access to energised liquid or electrodes whilst in use. Annual H&S inspection Use of electrophoresis will significantly reduce due to implementation of new technologies - will only be used for HPA typing. Technique will probably be fully superseded in a few years.	5	15/04/2022

7026	Welsh Blood Service	Final approval	03/10/2013	WTAIL liquid nitrogen automated filling system (low pressure) TT1-17	DATIX 3467 - transferred from paper assessment	Cryostorage refrigerators are sited so their open lids cannot damage the piping; The system has a regular Insurance inspection (Zurich); Piping, valves and controllers have regular maintenance by specialist contractors; Room has mechanical ventilation (monitored and alarmed by the EMS system); Laboratory Safety procedure POL(S)-009; Oxygen depletion sensors are present in the room, with audible and visual alarms; Induction training; Liquid Nitrogen emergency cut-off switches present both inside and outside of room to stop flow in event of problem: SOP 112/TTY, Management of the liquid nitrogen system in the Welsh Transplantation and Immunogenetics Laboratory. CryoVent system bleeds Nitrogen gas from lines before filling to prevent splashing. Use of cryo-protective gloves, coats, enclosed shoes and goggles mandatory. Laboratory safety procedures (POL-S 009), includes 'buddy system' for out of hours access	10	02/02/2022
6987	Welsh Blood Service	Final approval	23/09/2013	Operation of the BacT/ALERT	Operation of the System	Staff trained to SOPs Good Laboratory Practise Process Design Competency Assessment Appraisal Controls	5	06/01/2022
5394	Welsh Blood Service	Final approval	21/05/2012	Remove the class I HLA-A, HLA-B, PCR-SSP result from the UBM database for stem cell donor 15568709	Remove incorrect HLA type from UBM Database	IT working instructions Post implementation check performed	5	15/11/2022
2556	Welsh Blood Service	Final approval	23/04/2010	Missing Hazardous Items	9-4-10:The standard procedures for storage and transportation of all hazardous material created during a blood donation clinic should ensure that none of these items go missing. Hazardous material is defined for the purposes of this SOP as:- " Sharpsafes containing used items e.g. needles " Boxes containing contaminated waste " Vacutainers containing blood samples " Blood transportation boxes containing full blood donations/Non Conforming Donations	9-4-10: Standard operating procedure SOP: 014/BCT. WBS Transport record sheet (SOP: 022/BCT).Donor are health screened, before giving blood, which reduced the risk of contamination with blood borne pathogens. Training to SOP's. Agency Drivers have ID checks.	5	06/09/2022
175	Welsh Blood Service	Final approval	03/07/2007	Processing Platelets for Bacti Monitoring	25-Jun-2007 - Health and Safety Task Based Risk Assessment completed on QA Lab:processing platelets for bacti monitoring. Task: take samples from platelets and insert component into sealed bottle prior to entering into bacti monitoring system. Hazards: Microbiological status unknown, heat sealer, needle stick. See additional checklist.	SOP's in place covering all parts of procedure. Risk reduction process needlestick: rack placed inside microflow only one sample prepared at a time. Microbiological: if samples confirmed as positive process stopped regardless of stage of process. Heat sealer has protective cover - maintenance contact in place. No history of incidents. Ensure training records up to date for all staff performing tasks. 1/4/9 ongoing process. Risk reviewed 14-6-10, ongoing.	5	13/01/2022

ID	Is this a Private & Confidential Risk?	Risk Type	Division	Approval status	Service	Opened	Review date	Closed date	Title	Risk (in brief)	Rating (initial)	Rating (current)	Rating (Target)	RR - Current Controls
2486	No	Quality	Transforming Cancer Services	Accepted	Enabling Works	07/12/2021	07/01/2022		There is a risk that the Section 278 application takes longer than expected to be approved,	S278 Application There is a risk that the Section 278 application takes longer than expected to be approved, meaning that works traffic accessing the 'straight' TCAR are delayed, leading to a delay to construction and longer overall construction timeline.	9	12	6	This application process has started.
2480	No	Workforce and OD	Velindre Cancer Centre	Accepted	Medics	23/11/2021	23/12/2021		Current and predicted shortfall of oncologists by 2025	A recent census (RCR 2021) has predicted a shortfall across Wales in clinical oncologists by 2025. Medical oncologist were not included in the census but should also fall under this risk due to overlapping clinical roles. There is a current shortfall with predictions that this will worsen over the next 5 years (NB this is likely to be a gradual worsening over a period of time; the census predictions only go up to 2025 so no data suggests sudden improvement after that time). Due to the nature of clinical work, these gaps may fall unevenly, for example one team/tumour site could be seriously affected while others are not. Drivers behind this are: increasing clinical care/complexity (increase in patient numbers, increase in treatment options/complexity for each patient), new demands (eg regional AOS delivery), increasing trend to LTFT working and predicted retirements. On top of this there are potential impacts from Covid (ill health), pension tax impact.	15	15	4	Training places have increased however will not feed through by 2025. Actively seeking to recruit Developing new multi-professional ways of working (but there are also workforce limitations in other professional groups and the time taken to train new colleagues is a challenge)
2475	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Whole Service	19/11/2021	31/01/2022		A risk that increase in COVID and the Winter pressures period potentially impacts Int. Care project delivery	COVID-19 and Winter Pressures - A risk that increase in COVID-19 pressures and the Winter pressures period potentially impacts project delivery Cause: Increase in demand that requires project resource to focus solely on clinical work Increase in staff sickness leading to gaps in capacity/back fills requirements/prioritisation of clinical requirements	16	12	8	Update 10.12.21 - Regular meetings continue to take place with PMO to review status of projects and work plan. Activity monitored via the ICOG and sickness levels monitored by HODs. Mitigating actions: 1. Monitor staff sickness through the IC Operational Group 2. Monitor increase in demands via IC Operational Group 3. Update PM with resourcing issues for further escalation and re-prioritisation. Logged as a Project risk also for Integrated Care as may impact on project work streams

2472	No	Safety	Velindre Cancer Centre	Accepted	Operational Services	18/11/2021	31/03/2022		There is a risk that there is a traffic accident on site which may lead to someone being injured or damage to vehicles	All car parking areas on site. Vehicle movements on site including Staff, patients, deliveries and contractors. Pedestrian walkways on site. Specific risks include adverse interaction of vehicles and or pedestrians, slips trips/ falls, theft and vandalism.	15	10	5	Hazards identified: LPG storage cage close to road with no bollard protection (behind LA 2 and 3) Large vehicles encroach on coming traffic on narrow roads Pedestrians getting hit by cars Poor lighting resulting in slips, trips ,falls List control measures in place: Car park: 5mph speed restriction. Directional flow traffic system and road marking in place. Information signage directing visitors to the different departments on site. Designated ambulance parking areas and Ambulances fitted with audible reversing warning signals. Designated patient drop off/ pick up areas. Designated disabled parking spaces and pharmacy collections. Patient parking located near entrances allowing easier access for users. No parking zones are in place around the site and clearly visible. Dropped kerbs in place with tactile surface for pedestrians. Road and pavement surfaces in good condition
2460	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - Risk of privilege escalation on local user accounts	In the event of a successful cyber attack against Velindre Cancer Centre there is a risk that a local user account could be leveraged, to the spread the attack further due to excessive privileges.	20	5	5	Controls in place include national firewalls, Anti Virus & ACLs.
2458	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - End of Life Server Operating Systems on the VCC Network	There is a risk of a cyber security breach as a result of the ongoing presence of servers within the VCC network running the legacy Operating Systems (Server 2003, Server 2008 etc.), which may lead to the disruption or loss of IT services across VCC. There are numerous end of life server operating systems within Velindre Cancer Centre (including Windows 2003 & 2008), which increases the risk of a successful cyber-attack as these devices are not appropriately patched and vulnerable to exploit.	20	10	5	Current controls in place include Firewalls (DHCW), Antivirus software (Mcafee and Defender), access control lists and network segmentation.
2452	No		Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/02/2022		Intermittent IP telephony failure	There is a risk of ongoing (intermittent) IP telephony failures as a result of a recent upgrade to the Wi-Fi central controller, which does not fully support the older Cisco 7925 Wi-Fi IP phones in use across VCC, which may lead to telephony disruption for around 150 users.	15	12	3	New Wifi phones are in stock to replace the critical areas that require upgrades immediately. New Batteries are required to install these which will be ordered ASAP. Plan to replace all 149 handsets ASAP Attempt to fix the issue with the 7925 in the interim.
2451	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - No Client Firewalls on VCC devices	There is a risk of a cyber security breach as a result of the lack of client firewalls on VCC devices, which may lead to the disruption or loss of IT services across VCC.	20	10	5	National firewalls in place. Anti-virus may mitigate malicious software, if attempted.
2450	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - Inactive Edge Firewalls on VCC Servers	There is a risk of a cyber security breach as a result of VCC server firewalls being in 'passive' mode (meaning communications are not filtered), which may lead to the disruption or loss of IT services across VCC.	20	10	5	National firewalls used as protection for VUNHST.
2449	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - VCC Software Patch Management	There is a risk of a cyber security breach as a result of the lack of a formal patch management approach for software being used within VCC, which may lead to the disruption or loss of IT services across VCC.	20	10	5	Migration of VCC patch management onto Trust-wide 'PDQ' solution. Internal and external (NHS Wales) network protections (device / service isolation, firewalls etc.) in place.

2448	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - NTLM hashed credentials stored in memory	There is a risk of a cyber security breach as a result of NTLM hashed credentials being stored in memory, which can be leveraged and result in the disruption or loss of IT services across VCC.	20	10	5	Controls in place to prevent attackers from reaching the network i.e Firewalls, ACLs etc. However, if an attacker did access the network there are very little controls in place that would prevent lateral movement.
2447	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - Cleartext credentials stored in memory	There is a risk of a cyber security breach as a result of due to the storage of account credentials in 'cleartext' format, which can be leveraged and result in a loss of IT services across VCC.	20	10	5	Controls in place to prevent attackers from reaching the network i.e Firewalls, ACLs etc. However, if an attacker did access the network there are very little controls in place that would prevent lateral movement.
2446	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - Weak Passwords in use on Admin / Privileged IT accounts	There is a risk of an external agent compromising VCC admin/privileged IT accounts as a result of the use of weak passwords in use within the VCC Digital Services team, which may lead to a cyber security breach and/or the loss of IT services across VCC, resulting in the disruption or loss of IT services across VCC.	20	10	5	Various Cyber Security tools in place including national firewalls, AV and ACLs which provides defence in depth. Work ongoing to remove weak passwords.
2445	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - Risk of malicious payloads not being blocked by anti-virus (McAfee)	There is a risk of a cyber security breach as a result of malicious payloads not being blocked by VCC anti-virus (McAfee),, which may lead to the disruption or loss of IT services across the VCC.	20	10	2	VCC currently migrating to Defender Anti-Virus and will be moving towards Defender DLP. Mcafee still in use on various servers and DLP enabled.
2444	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - CVE-2019-0708 BlueKeep Vulnerability	There is a risk of a cyber security breach as a result of the presence of the CVE-2019-0708 BlueKeep vulnerability within the VCC network, which may lead to the disruption or loss of IT services across VCC.	20	10	5	Affected Radiology services are protected behind IT security (firewalls - external to NHS Wales) with access to those systems limited to a small number of named access.
2442	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	29/10/2021	01/05/2022		Cyber Security - End of Life Desktop/Client Operating Systems on the VCC network	There is a risk of a cyber security breach as a result of the ongoing presence of devices within the VCC network running the legacy Windows Operating System (Windows 7, XP etc.), which may lead to the disruption or loss of IT services across VCC.	20	10	5	National Firewalls. Anti-virus controls in place.
2440		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	18/08/2021	29/11/2021		Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics	SACT & MM service are unable to significantly reduce the capacity of SACT daycase clinics and concern re: reducing pre-assessment clinics over the Go-Live period due to cyclical nature of SACT treatment and potential consequences of delays for SACT patients Mimimal amount of SACT treatments can be paused due to nature of service provision. Clinics are monitored regularly to manage ongoing constraints with capacity.	16	16	6	Regular capacity review meetings by SACT & MM leads to discuss ongoing capacity constraints 23/08/21 - There are a small amount of specific regimens where there is scope to reschedule treatment dates and therefore reduce patient numbers for go-live week. Decision to reduce capacity at go live is a strategic level decision requiring project board/SMT/Exec approval. Risk can only be fully considered when go live date is agreed.
2438		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	21/06/2021	29/11/2021		Digital Health & Care Record Risk DHCR043(R) - Completion of process maps and ways of working	Further maps now having to be drafted due to development of e-IRMER and migration issue. e-IRMER workflow maps required, increased workload for project team, with limited resource.	20	12	9	Project team structure undergoing revision & recruitment planned. Workshop to be arranged to finalise workflow process maps with clinical input
2437		Workforce and OD	Velindre Cancer Centre	Accepted	Radiotherapy Services	22/10/2021	29/11/2021		Digital Health & Care Record DHCR042(R) - Delay in new Radiographer graduates starting, likely to be October/ November 2021	Delay in new Radiographer graduates starting, likely to be October/ November 2021. Service will be relying on locum/ agency staff - more staff to train and higher risk of error.	20	20	12	DH&CR training team can offer flexible training sessions to fit around clinical commitments. DH&CR team can provide financial assistance to support additional staff resource.
2436		Workforce and OD	Velindre Cancer Centre	Accepted	Radiotherapy Services	22/10/2021	29/11/2021		Digital Health & Care Record DHCR041(R) - Service expecting a 'surge' in patients end of October 2021	Service expecting a 'surge' in patients end of October 2021. Will place increased pressure on service & staff, difficult to release for training & UAT. Risk of staff burnout.	16	12	12	DH&CR training team can offer flexible training sessions to fit around clinical commitments. DH&CR team can provide financial assistance to support additional staff resource. To continually review & monitor situation via workstream leads

2432	No	Workforce and OD	Velindre Cancer Centre	Accepted	Whole Service	05/10/2021	31/01/2022		Risk that DHCR work may be delayed as result of staff prioritising service demands & patient care	Risk that DHCR work may be delayed as result of staff prioritising service demands & patient care DHCR036(R) - DHCR project support: Availability of Inpatient Staff, Psychology, Therapies, Infection Control, Clinical Coding, Assessment Unit and Supportive Care staff and CNSs, to support DHCR project due to continued increased demand across all these services. 1. Project timelines could be delayed as training, testing may be seen as secondary to providing clinical care. 2.Once ways of working have been identified, time required to employ, train any additional resource required could impact project implementation	16	12	4	Update 10.12.21 - Regular meetings continue to take with project leads. Ways of working almost completed for IC. Some process maps completed and signed off by service. Update 03.11.21 -Regular update meetings scheduled with project team leads to review progress and outstanding work. Attendance at Project Team meetings. Update 27/10/2021 -Dedicated time made available for operational lead. Continuous review of service capacity across the inpatient workstream prioritisation process. Weekly reviews with the Department Leads to monitor progress in DHCR project, but also to sense check the demands of the services
2431	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Programme	23/07/2021	31/12/2021		There is a risk that the impact of Covid-19 on Programme activity will continue to cause longer-term disruption	There is a risk that the impact of Covid-19 on Programme activity will continue to cause longer-term disruption resulting in potential misalignment of project activity and as such further impacts to Programme Plans and Deliverables	16	12	4	1) Project plans being reviewed with programme support to ensure they are up to date and where projects are now 'unpaused' to bring plans in line with more mature projects. Complete 2) Master Programme Plan updated to reflect update to projects and to show dependencies across projects and programme activity. Complete 3) Review and reporting on Master Plan to PDB and Scrutiny committee. Ongoing
2428	No	Compliance	Velindre Cancer Centre	Accepted	Nursing	02/08/2021	29/11/2021		There is a risk of increased infection transmission due to poor ventilation.	Concerns have been raised around the poor ventilation and seasonal extremes of temperature that exist within inpatient areas at VCC impacting both staff and patients, this risk assessment relates to First Floor (FF) ward. Patients receiving care in the inpatient ward at VCC are often immunocompromised and/or neutropenic and therefore would benefit from improved air quality which can only be guaranteed through a compliant mechanical ventilation system. See document for full description	16	16	9	UPDATE 03.11.21 - Further detailed planning to be undertaken by estates and operational services teams in conjunction with nursing team with timescales and decant plan. * Infection control and prevention measures in line with Trust polices. Including regular audit, training, enhanced cleaning etc. * Additional COVID19 precautions - Use of PPE, regular testing of patients and staff etc. * Full root cause analysis undertaken to ascertain cause(s) of any infections. * Business Case currently under development to seek funding for compliant ventilation system.

2424	No	Safety	Velindre Cancer Centre	Accepted	Therapies	28/07/2021	25/01/2021		Risk of WT breaches & poor patient experience as a result of reduced Dietetic staffing levels	There is a risk that there could be breaches of waiting times, reduced patient experience and outcomes as a result of reduced staffing levels in the Dietetics department which may and stress on the remaining staff members. Due to x1 maternity leave (Clinical Lead DT) and x1 LTS (band 6 PSU cover) with the Dietetic department the workforce is currently reduced from 5wte qualified staff to 3.5wte. Scrutiny approved 1.0wte band 6 DT and an internal upgrade band 6-7. Unfortunately we did not recruit into either of these posts. Our locum also finished on 7th July 2021. Scrutiny have however approved an external band 7 Clinical Lead DT 1.0wte, which is currently out to advert and in the recruitment process. There is therefore a current risk on the workforce that will hopefully be mitigated by recruitment into the vacant post. For the next 2-3 months, there will not be the required capacity to deliver a high quality, timely DT service. This will lead to breaches of waiting times, reduced	12	12	6	Remaining DT staff are trained to appropriate levels and clear re what they can and cannot do Clear prioritisation criteria is in place Discussions with Senior managers and exec colleagues to make them aware of situation Locum agency searches. Temporary cessation of some services will be required. Recruitment for the 1x external Clinical Lead Dietitian vacancy is underway
2423	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Integrated Radiotherapy Solution	08/09/2021	04/02/2022		Risk that IRS evaluation process is delayed due to resource pressures	There is a risk that as the nVCC Competitive Dialogue clashes with the IRS Final Tender evalutation, there is pressure on resource availability leading to delays in finalising the evaluation process	12	12	6	1) Works has started to understand which staff and resource are impacted to explore availability and potential impact of this to the Project
2418	No	Reputational	Transforming Cancer Services	Accepted	Programme	05/10/2020	14/01/2022		Risk that TCS Programme does not have support from Stakeholders	Risk that the TCS Programme does not have support from Stakeholders (pts, HB, politicians, WG, clinicians) Causes - Lack of engagement with all relevant stakeholders/ Misinformation shared from external sources / Inconsistent engagement from specialist resource / Change of views over a period of time / Lack of alignment between TCS programme and other strategic priorities across the organisation and individuals / Political leadership change Consequences - WG and LHBs do not support key decisions / Reputational damage for Velindre Trust as an organisation / Petitions & opposition to plans for TCS Programme / Delays to programme and project progress / Failure to deliver some/all of programme benefits	16	12	4	1) Further engagement is being planned with specialist stakeholders – broader and more targeted who are not fully supportive. Programme Communications resource in place & recruitement of additional comms resource to support comms/engagement activities 2) Better use of technology being reviewed and rolled out to share key messages 3) Variety of stakeholder events held over a number of years - complete 4) Clinical workshops held throughout Programme lifetime - ongoing 5) Professional meeting forums held e.g. DoPs, MDs, CEO's etc - ongoing 6) Ongoing engagement with local elected members (MS, MP, Councillors) 7) Dialouge beteen exisiting cancer forums e.g. cancer leads in SE Wales HBs - ongoing through CCLG 8) Monthly meeting with WG Head of
2417	No	Reputational	Transforming Cancer Services	Accepted	Programme	08/07/2020	14/01/2022		Risk that there is lack of TCS Programme Comms Plan	There is a risk that there is a lack of TCS Programme wide communications plan resulting in the objectives of projects and interdependant links are not communicated effectively and the wider networked clinical model not understood.	12	12	4	1) Revise TCS website - complete 2) Improve internal TCS teams Comms - complete 3) Improvements to intranet - started 4) Improvements to the link between Programme Governance and Comms - tbc
2416	No	Quality	Transforming Cancer Services	Accepted	Transforming Cancer Services	30/06/2020	31/01/2022		Risk that COVID may lead to delays on Project progress	There is a risk that potential further waves of COVID may lead to delays that effect the development & key activity of the outreach project	20	12	6	Agreement with HBs of ways of working during any possible covid resurgence to ensure that project is able to continue making progress

2415	No	Quality	Transforming Cancer Services	Accepted	Radiotherapy Satellite Centre	17/12/2019	05/01/2022		Risk that key resource involved in a number of projects leading to not enough capacity to fulfill commitments	There is a risk that as key resource are involved in both the RSC, IRS & nVCC Projects which are being managed in parallel could mean there is not enough capacity to fully commit to both projects. This could impact on the quality of the work or the ability to complete the requirements to agreed schedules.	16	12	6	1) A matrix to consider commitments of colleagues to consider priorities and timings to be developed. - ongoing 2) Resource review to understand if additional resource may be required to support project teams. 3) Alignment of meetings and agenda's for 'pressured' colleagues to be looked at to manage this. E.g. when there are items in meetings that are not relevant they can be released from the meeting
2413	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Radiotherapy Satellite Centre	29/06/2020	05/01/2022		Risk that Radiotherapy Satellite Centre will not have required skilled staff in place to run facility	There is a risk that the Radiotherapy Satellite Centre will not have required skilled staff in place to run the facility once ready to be operational. This would impact on radiotherapy capacity and resilience for the Trust.	15	12	6	1) An integrated Radiotherapy and Physics workforce plan is required to consider the service as a whole taking account of a full operating model that includes current activity, projected activity, IRS and RSU. 2) Provisions from across the whole service will be reconfigured to meet the requirements of the satellite unit.
2411	No	Partnerships	Transforming Cancer Services	Accepted	Programme	04/11/2020	31/01/2022		Risk that there is potential misalignment of scope and timeliness of decisions between VF & TCS	Risk that there is potential misalignment of scope and timeliness of decisions between VF & TCS Causes - Poor communications between VF & TCS teams Delays in agreement of VF scope & governance arrangements Lack of clarity of scope for VF Lack of understanding of the interdependent timescales and activity Lack of knowledge and understanding of both programme objectives Consequences - key deliverables get missed as not picked up by either TCS or VF Delaying progress of current live projects Change of priorities Adjustment of plans Agreements / decisions have been made already (i.e. could be contractual agreements in place) TCS may not be delivering the agreed VF scope & clinical outputs Disengagement of stakeholders	12	12	6	1) Agree clear scope and role of VF and its programme board. Complete 2) Understand the interfaces that VF has on the scope of TCS and its programme board to be clear about the delegations that result. Complete 3) Communicate the scope of both and any implications for TCS. Complete 4) Prioritisation of key work items and workshops to agree the appropriate routes for decision making. Complete - new ways of working with EMB Shape, Transformation Board & Strategic Infrastructure Board and Velindre Futures in place with clear governance structures in place 5) Understanding and agreement of key stakeholders within and outside the organisation. Stakeholder mapping reviewed, no significant changes within and outside of organisation. Complete
2410	No	Workforce and OD	Transforming Cancer Services	Accepted	Programme	05/10/2020	18/03/2022		Risk that there will be inadequate and / or insufficient workforce capability and capacity to meet needs of the TCS Programme	Risk that there will be inadequate and / or insufficient workforce capability and capacity to meet the needs of the TCS Programme outputs. Causes - Workforce supply not available in required professionals groups or with required skills / Requirements for workforce capacity and capability no longer accurate. Consequences - Inadequate staffing of Velindre facilities across the SE Wales region / Impact on providing treatment and care to patients	12	12	2	1) Service planning is sufficiently developed to facilitate effective workforce planning techniqies to be applied 2)Ensuring each project has clear and well developed workforce plans which are predicated on clear service plans 3) Clarity of expectations for workforce team involvement 4) Clarity of Role & Responsibility for Workforce planning input team in relation to Project & Programme need 5) Workforce team to support service to ensure the right people are available and allocated to support

2408	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Integrated Radiotherapy Solution	22/04/2021	04/02/2022		Risk that IRS Project FBC is delayed or not approved	There is a risk that the approval for the FBC for the IRS Project is delayed or not approved, due to changes in approval timescales which would lead to delays to project delay, project abandonment impacting on other TCS Projects (nVCC & RSC) deliverables	16	12	8	1) Engagement with Capital & Treasury teams - ongoing 2) Previous presentations to IIB - complete 3)OBC shared with WG Officers for comment - complete 4)WG notified of timescales for FBC so they can align resources - complete 5)Specialist advisors used to support delivery of Business Case - ongoing
2407	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Radiotherapy Satellite Centre	17/01/2020	05/01/2022		Risk of overlapping timeframes and interdependancies between RSC & IRS Projects	There is a risk that as the IRS Project needs to be phased in parallel with RSC Project, due to overlapping timeframes and interdependancies resulting in the RSC project being restricted to planning assumptions until the Equipment Project is concluded which has an inherent risk.	16	12	4	1) RSC project requires a clear view IRS Project Risk landscape and links between the 2 projects in terms of risk registers and project plans 2) Ensure design is flexible and futureproof to allow for IRS solution 3) Review impact of delays to IRS Project on RSC Timeline
2405	No	Quality	Transforming Cancer Services	Accepted	Transforming Cancer Services	30/06/2020	31/01/2022		Risk that projected growth assumptions for Outreach will be less than required	There is a risk that the projected growth assumptions for outreach delivery of SACT, ambulatory care and outpatients is less than will be required, leading to undersized locations.	16	12	6	1) Re-run projections around growth assumptions. 2) Activity model will be re-run with outputs presented to project Board. Any additional requirments will be presented to the Programme Delivery Board with recommendations. Individual meetings with Health Boards to ascertain their requirments will be undertaken.
2403	No	Quality	Transforming Cancer Services	Accepted	Enabling Works	08/06/2020	07/01/2022		Risk that enabling works construction exceeds timescale	There is a risk that enabling works construction, including bridges, exceeds 15 months, leading to delays to nVCC construction and incurring financial loss claims from the MIM contractor.	12	16	9	1. Regular review of possible areas which may cause delay: Most recent review of the plan shows only minimal slack between the end of the enabling works construction and beginning of MIM construction Ongoing 2. Partial mitigation through normal contract condition re liquidated and ascertained damage – where events in the contractors control can result in compensation for costs incurred by the client resulting from time or cost overruns. Need to be within expected reasonable limits. Care required in setting that limit to steer away from punitive damages as few contractor would price the works, pushing up tender prices. Scaling delay damages clause added to tender documentation to ensure contractor is incentivised to complete work on time. Complete 3. Focus to be applied to detailed construction programme following return of FW D&B bids. Complete
2402	No	Performance and Service Sustainability	Transforming Cancer Services	Accepted	Transforming Cancer Services	10/05/2021	31/01/2022		Risk of time-consuming infrastructure work	There is a risk that time-consuming infrastructure work i.e. the refurbishment of a current site or identification of a new build is required to deliver the agreed outreach model of care. This could lead to delays in outreach services not being established or operational ahead of the new VCC as agreed within Programme objectives	16	16	9	1) Identify location 2) Identify refurb / new build required 3) Establish level of local engagement with CHCs/public required 4) Identify appropriate resources from all HBs & VUNHST (inc Project Leads, Planning etc) to ensure project is supported and managed to align with project & programme timelines 5) Establishment of ownership and governance of Project within TCS/VF environment

2401	No	Workforce and OD	Transforming Cancer Services	Accepted	Integrated Radiotherapy Solution	26/02/2021	04/02/2022		Risk of insufficient resources being made available to the Project	There is a risk that insufficient resources (people) being made available to the project will have an adverse impact on the quality of the procurement process	16	20	8	1) Detailed project Plan to identify resource requirements 2) Approved Capital Budget for the Legal & Staffing Costs 3) Regularly monitor staff availability (annual leave & sickness)
2400	No	Workforce and OD	Transforming Cancer Services	Accepted	Transforming Cancer Services	30/06/2020	31/01/2022		Risk that there is lack of project support	There is a risk that the lack of appropriate project support from the programme will lead to delays in developing the solutions required for the project success.	20	20	6	1) Programme Board will look to allocate resources as appropriate. Funding request to WG to support ongoing work - Ongoing 2) Clarification required on whether Outreach Project is an Operational or an Infrastruture Project - Ongoing TBC
2397		Safety	Corporate Services	Accepted	Quality and Safety	18/05/2018	28/10/2021		Infection Prevention & Control Service including staff attendance	1. Reduced capacity in the Infection Prevention and Control Team (IPCT) will reduce service provision within Velindre NHS Trust as operational workload will be prioritized. 2. Reduction in microbiology consultant ward rounds due to decreased capacity within the Public Heath Wales laboratories (PHW). Core service continues but educational opportunities will be missed and robust antimicrobial review may not occur. 3. Multi-disciplinary approach to root cause analysis investigation will not occur due to reduced medical input driven by a reduction in the number of doctors within VCC. This will compromise the quality of the clinical review as medical expertise will be absent and opportunities for learning to inform practice will be missed. 4. There has been persistently poor medical attendance at core IPC meetings such as RCA review, AMT / sepsis leading to reduced engagement. This will hinder required service	16	12	9	Control Measures in place: 1. Risk assessment in place for ICNet and duplication of data entry but it doesn't take into account additional demands of imminent National Enhanced surveillance. 2. Core Microbiology service provision continues but opportunities for learning and clinical review missed as reduction in weekly microbiology ward rounds to every 3/ 4 weeks
2396		Performance and Service Sustainability	Corporate Services	Accepted	Workforce and OD	20/04/2017	28/10/2021		PADRs	Not all employees are receiving meaningful PADRs -PADRs do not underpin the requirement of the Velindre NHS Trust Integrated Medium Term Plan (IMTP) and the Trust Values. -Failure to complete quality PADRs will have direct impact on the All Wales Pay Progression Policy. -Employees do not understand what is expected of them in their role (objectives not agreed for next 12 months) and do not take responsibility for their own performance and development. -Personal Development Plans are not established for next 12 months - missed development opportunities for employees. -The Trust are not easily able to audit the quality of PADRs undertaken.	9	12	6	-PADRs do not underpin the requirement of the Velindre NHS Trust Integrated Medium Term Plan (IMTP) and the Trust Values. -Failure to complete quality PADRs will have direct impact on the All Wales Pay Progression Policy. -Employees do not understand what is expected of them in their role (objectives not agreed for next 12 months) and do not take responsibility for their own performance and development. -Personal Development Plans are not established for next 12 months - missed development opportunities for employees. -The Trust are not easily able to audit the quality of PADRs undertaken.

2395		Safety	Corporate Services	Accepted	Quality and Safety	26/05/2020	28/10/2021		Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	15	12	9	1. As noted above, site has holistic fire strategy where compartmentation plays a key role 2. Site has high level of fire detection to WHTM 05 (Firecode) 3. Provision of fire safety training to support implementation of fire safety strategy 4. Program of fire safety risk assessments and annual fire safety audits including the identification and assessment of compartmentation 5. Inspection of compartmentation by 3rd party accredited surveyors and receipt of report and remedial actions in 2020 6. In support of management and prevent, Department managers responsible for regular workplace inspections including the monitoring of local fire precautions 7. Fire doors subject to regular visual inspection as part of Estates planned preventative maintenance regime 8. Consideration of fire risk assessment findings (including compartmentation issues) as part of
2394		Performance and Service Sustainability	Corporate Services	Accepted	Governance	21/04/2016	28/10/2021		Fundraising Income Targets	This risk applies to external charities as well as those based on site at Velindre Cancer Centre. However, the control measures and focus of the remainder of this risk assessment relates to onsite charities.	12	12	3	The Trust has a clear fundraising strategy in place. Velindre Cancer Centre's branding guidelines introduced in July 2015 states that: - The Velindre University NHS Trust, NHS Wales, Velindre Cancer Centre and Velindre Fundraising will be the prominent brands on Velindre Cancer Centre premises. - Only 'Velindre Fundraising' and 'Friends of Velindre', charities which raise funds exclusively for Velindre NHS Trust, will be allowed to display publications, materials or media alluding to any form of fundraising on Velindre Cancer Centre premises. - Non-fundraising materials from other charities and organisations will be promoted where there are clear benefits
2393		Safety	Corporate Services	Accepted	Quality and Safety	19/06/2020	28/10/2021		Infection control	There is a risk that staff could contract COVID-19 in their working environment as a result of poor social distancing or hygiene Majority of control measures in Welsh Government guidance now in place. However the work on site utilisation and linking of this to the capacity planning framework is complex	12	12	9	To be inserted

2389	No	Safety	Velindre Cancer Centre	Accepted	Therapies	28/05/2021	31/01/2022		Risk that patients with altered airways may not receive appropriate care from the MDT clinical team	There is a risk that patients with altered airways may not receive care from the MDT clinical team with the necessary skills and competencies due to the frequency of staff being required to use these competencies (months between patients) and therefore their ability to train and maintain. This situation has been exacerbated by the retirement of a specialist nurse with expertise in airways management. Definition of these patients fall into 3 groups; • Head and neck patients with tracheostomy or laryngectomy stoma. • Respiratory patients requiring suction • Palliative patients requiring suction	12	12	6	Update 10.12.21 - Recruitment underway for a Head & Neck Advanced Nurse Practitioner with interviews taking place w/c 13.12.21. MDT discussions take place pre-admission for this group of patients to assess needs and treatment requirements. Update 03.11.21 - additional mitigating actions: We are currently in the process of recruiting a Head & Neck Advanced Nurse Practitioner whose role will be to provide training for staff in the management of altered airways and ensure that there is appropriate cover for this service. MDT discussions take place pre-admission for this group of patients to assess needs and treatment requirements. Additional training has been sourced from C&V UHB and a Speech & Language Therapist with the relevant skills and expertise has recently been appointed to the VCC Therapies team. •Group 1 patients •1 x SLT works Mon/Tues and Thursday and able to see these patients with good skill level
2388		Safety	Velindre Cancer Centre	Accepted	Nursing	18/06/2021	31/03/2022		There is a risk of high temperatures, increased spread of infection a result of lack of ventilation	OPD Environment - Temperature of the Outpatients department There is a risk that during the summer months, due to a lack of ventilation and air conditioning in the outpatients department, the temperature exceeds that which is comfortable or safe for patients and staff. There is a risk that due to the extremes of heat, patients and staff could become unwell. Wall mounted fans should not be used due to covid restrictions.	12	12	8	Doors and windows left open where possible to increase ventilation. Staff providing cold drinks to patients in the department throughout the day. Increased seating outside the OPD entrance. Staff issued with lightweight scrubs. Staff to take regular breaks to ensure they remain hydrated.
2361		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	12/06/2020	01/12/2021		Radiotherapy Dept - COVID Social distancing	COVID Social distancing – Radiotherapy In response to national guidance to reduce the risk of contraction of COVID-19 due to close contact with persons and objects, social distancing measures have been introduced into the radiotherapy department in line with COVID-19 guidance. This may result in reduced capacity and the contraction of the radiotherapy service.	16	12	2	High-risk staff shielding. Symptomatic staff isolating. Staff aware of social distancing guidelines. See attached risk assessment for controls within each zone. 22.7.20. No change to actions. 20.10.20. Risk reviewed. New lockdown announced 19.10.20. No change to social distancing measures in radiotherapy department pj. 16.2.21. No change to measures in radiotherapy pj. 21/5/2021 – Risk reviewed by PJ & CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. High risk staff are no longer required to shield, but are advised to continue to work from home where possible if a safe working environment with VCC cannot be provided. The need to maintain the controls mentioned above continue, to ensure safety of staff, patients and the radiotherapy service.

2345		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	14/09/2020	06/12/2021		Radiotherapy Dept - Change to service due continued response to Covid19	There is a risk that there will be a continued change to service as a result of Covid 19 measures which may lead to contraction of the service and the creation of a waiting list As the service moves in to the recovery phase there is a continued risk of the availability of staff being impacted through infection prevention and control measures, thus potentially impacting on the service ability to deliver the required capacity to meet demand 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix.	9	16	1	Continuing to work through recover phase towards business as usual. Covid contingency plan in place to be deployed if required, ie, deferral of benign, prostate monotherapy, prostate external beam and skin if necessary 'Pod' working in place across radiotherapy clinical delivery service to minimise risk of cross infection Development of outsourcing contract to private provider to deliver external beam for prostate and breast 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix. Mitigation 1.Department is currently working under business continuity, with 2x weekly meeting with SLT, Radiation Service and Radiotherapy Service managers to discuss departmental position and actions being undertaken. 2.Undertaking escalation work to minimise breaches
2343		Compliance	Velindre Cancer Centre	Accepted	Estates	20/12/2010	27/07/2021		Water Systems - Legionella	Maintaining the water systems free of Legionella at the Velindre Cancer Centre using a range of monitoring and control systems for water treatment and flushing across the VCC site. Continual improvement to remove redundant pipework and upgrade water systems where possible.	20	5	5	Regular monitoring of water temperatures. Regular testing and sampling. HEPA filters on shower outlets in the patient areas. Risk assessment and audit of water system by external consultant. Water Safety Group in place with appropriate members which meet regularly. Water Safety plan and written scheme are in place. Pre-planned preventative maintenance are also on FACTS and are routinely undertaken by competent staff. Removal of redundant pipe work where possible. Legionella management policy in place. Responsible person trained. Water sampling regime has been constructed and reviewed by Water Safety Group members and is currently in place on all sites.
2342		Safety	Velindre Cancer Centre	Accepted	Estates	22/10/2013	03/08/2021		Risk of patient using curtain track as ligature point	Risk of patient using curtain track as ligature point.	10	5	5	Approved contractors will install and validate anti ligature curtain rails where it has been identified via discussions with department managers as they are required.

2341		Safety	Velindre Cancer Centre	Accepted	Estates	02/12/2006	03/08/2021		Risk of injury to staff/contractors when working at height where there is a lack of edge protection	Injury to persons from falling from roof, and exposure to radiation whilst being on the roof.	5	5	5	Method statements and permits to access roofs from contractors. Working at heights has been a topic during team meetings to raise Estates staff awareness. Roof edge protection fitted to commonly accessed areas. Access to roof areas controlled through gate and locking system.
2340		Compliance	Velindre Cancer Centre	Accepted	Operational Services	22/10/2013	03/08/2021		Risk of injury to staff, patients, visitors if equipment hasn't been PAT tested	There is a potential risk of injury to building users if equipment have not been PAT tested.	15	5	5	No equipment to be used on site unless it has a valid PAT sticker. Patients equipment is tested and PAT sticker is applied (staff are responsible for informing Estates via the FACTS system of patients' equipment which requires testing. Industry Guidelines consulted to decide frequency of testing for IT equipment (every three years). Medical equipment is tested by Bio engineering (outside of the Estates remit). All other equipment is tested annually. Asset register of appliances created during testing by contract labour. Department managers are informed prior to annual testing taking place within their department. Any incidents regarding portable electrical equipment are raised on DATIX and discussed at the Electrical Safety Group.
2339		Safety	Velindre Cancer Centre	Accepted	Estates	07/04/2007	03/08/2021		Risk of injury to staff whilst using single and double extension ladders and steps	Risk of injury to staff whilst using single and double extension ladders and steps.	15	5	5	Operative using ladder will inspect before use and report any defects. Safety man should be utilised when required. Barriers are available should they be required. Steps and ladders are regularly inspected and results are documented. Ladder training provided to staff.

2338		Safety	Velindre Cancer Centre	Accepted	Estates	03/11/2005	01/09/2021		Risk of injury or ill health to staff whilst working in subterranean ducts (confined space)	Maintenance staff working in confined spaces such as the subterranean service ducts to either run in new services or to maintain existing ones. The ducts are not full height and therefore staff will have to crawl along these spaces. In the event of a person collapsing, difficulties would arise with emergency evacuation. Issues noted when working in confined areas include, but are not exclusively, cramped conditions, heat, gas, fire/explosion, radon gas, exposure to asbestos and problems carrying out an emergency evacuation in the event of injury or illness.	15	5	5	Staff not trained in confined spaces are prohibited from entering confined spaces under any circumstances, therefore should an occasion arise when entry to a confined space is required out of hours and an untrained Estates worker is on call, he will have to contact one of the confined space trained tradesman to assist. Members of the Estates department have received confined space training and two have received confined space supervisory training. Lighting has been upgraded in the ducts. An asbestos removal has taken place in the ducts, however residual asbestos is still in the Horseshoe and main duct therefore Estates workers are not to enter either the Horseshoe or main duct. An asbestos survey was carried out in the Whitchurch duct and no asbestos was recorded (additional sampling is to take place). Staff have completed Health and Safety training. Hot works permit to works are in use on site. PPE is available for all members of Estates (this includes CAT B disposable suits and over boots, FP3 masks, safety shoes, and gloves)
2336		Safety	Velindre Cancer Centre	Accepted	Estates	08/06/2009	03/08/2021		Risk of injury or ill health to Estates staff whilst working in a lone working environment	Risk of injury or ill health to Estates staff whilst working in a lone working environment and a possible delay in receiving medical treatment in the event of an adverse event. Due to slips, trips and falls, contact with machinery, contact with electricity, serious illness, overcome by noxious fumes, falls from height or coming into contact with an aggressive violent person.	15	5	5	Safety shoes with non-slip soles provided. Hard hat areas identified or hazard tape used to identify bump hazards. Toughened gloves available. Two way radios are available should the Estates worker deem them necessary. Machinery has guards to prevent entrapment. Trained qualified staff to work within their capabilities. Staff carry Cisco WIFI phones and/or mobile phone. Some plant rooms have telephones Permit to work required for electrical work. Ongoing program to barrier roof areas. Violence and aggression training is provided. Health and Safety training is provided. All plant rooms have automatic smoke detection. Co2 detector is fitted in the main boiler house. All boiler rooms have ventilated doors. Regular boiler maintenance is carried out. Basic Life Support training level 1 with practical CPR for maintenance technicians is delivered. Outside stairs are illuminated. Medical staff available on site should a medical emergency occur. Maintenance staff will assess the need to use a safety person when required (out of hours
2329		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	09/06/2021	29/11/2021		Digital Health & Care Record DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics	There is a risk that the 'cashing up' of the daycase clinics in WPAS (including SACT, Clinical Trials, OPs and ambulatory and supportive care) will not be completed as required. Documentation and performance data will not be accurate. Protracted administrative process causing stress to clinical teams whose primary focus is clinical care.	16	16	16	SACT, Clinical Trials, Supportive care an OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role Attendance data is reviewed manually by the nursing administration team when they process the daycase clinics to change certain attendances to WACs as necessary. This is not comprehensive and does not cover all of the clinics at present.

2328		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	09/06/2021	29/11/2021		Digital Health & Care Record DHCR035(R) - SACT & Medicines Management – processes	The process of booking / admitting patients as they arrive in real time on the unit is time consuming and complex whilst clinical staff are concentrating on safe delivery of care Potential risk to patient safety because clinical staff are distracted by the administrative task Documentation will not be accurate impacting on clinical decision making Protracted administrative process causing stress to clinical teams whose primary focus is clinical care	16	16	16	SACT, Clinical Trials, Supportive care and OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role
2326		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Operational Services	24/05/2021	31/12/2021		There is a risk that the Service will be unable to significantly reduce the capacity of clinics over the Digital Health & Care R	A Minimal amount of outpatient activities can be paused due to the nature of the service provision. Some non-cancer and follow-up clinics can be reduced however. Clinics will be running at normal capacity - ideal situation on a large go-live would be for reduced clinics for a few days after go-live to allow users a little additional time to get used to the new system.	16	16	9	1. Service managers and teams to be available on site. 2. Training champions/super users to support on site during the Go-Live period. 3. Minimise annual leave as much as possible.
2325		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	09/06/2021	29/11/2021		Digital Health & Care Record DHCR026(R) - SACT & Medicines Management – Affect of Canisc Shutdown on the Department	There is a Risk of Canisc being shut down on 17/09/21 before SACT & MM have completed required activity in Canisc. Clinical teams will be unable to access patient records during Canisc switch off, leading to delays in decision making and potential error, along with poor patient experience There could also be an impact on data migration if all SACT switch off activities are not completed in time	20	12	8	All clinical teams and SACT administration to complete all work before switch off deadline. During this time, SACT & MM have requested that switch off of Canisc be delayed until 19:00 on Friday 17/09/2021. This aligns with RT & OP clinics
2324		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	09/06/2021	29/11/2021		Digital Health & Care Record DHCR024(R) - SACT & Medicines Management – DH&CR Project Support	DHCR024(R) - DH&CR project support: There is a risk regarding the availability of SACT support for the DH&CR project, due to increased demand on the SACT service if & when SACT surge demand occurs or SACT capacity reduces The SACT DH&CR operational lead also provides clinical leadership for SACT booking services. Impact on clinical patient escalation & prioritisation process for SACT scheduling with potential impact on clinical outcomes if SACT DH&CR operational lead is unable to provide sufficient time to this element of service should SACT demand increase or capacity reduce. Conversely, there is the potential impact on the DH&CR SACT project progressing if resource is focussed on clinical prioritisation	16	12	8	Continuous review of service capacity of SACT and MM clinical team to support clinical prioritisation process. Twice-weekly review undertaken. Daily contact can be made with the booking team if required. If the workstream operational lead is required by the service, this resource would not be able to be replaced.

2296		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	11/01/2021	29/11/2021		Digital Health & Care Record DHCR010(R) - Data Migration Resource	DHCR010(R) - The Head of Information who manages the Business Intelligence (BI) Service within VCC is actively involved with the Data Migration work. This includes assisting the Data Migration Specialist with the development and testing of data migration extracts from Canisc to WPAS. In addition, the Head of Information provides subject matter advice and guidance to the whole project team. There are currently competing priorities on the Head of Information time due and the need to delivery Capacity and Demand planning, ad hoc information requests etc. during the COVID pandemic, whilst supporting a new team. The impact of these competing demands and a number of new team members is the reduced availability of focused time for the Head of Information to undertake the complex data migration work. This has impacted directly on the capacity of the Head of Information to assist in the development and testing of the data migration extract and provided support/guidance in a timely manner	15	15	6	Clear prioritisation of the BI Service work and Head of Information's workload is required. Notification to service users of unavoidability of BI Head for 3 weeks period in April 2021. A deep dive is planned to support this prioritisation. 09/06/2021 - LM & JH reviewed risk - situation still stands. LM to discuss with WJ.
2290		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Nursing	07/11/2019	31/03/2022		Patients at risk of being lost to follow up	Patients at risk of being lost to follow up Due to the volume of patients and the processes by which patients are booked for follow up appointments, There is a risk that patients could be lost to follow up.	10	12	8	UPDATE June 21 - Third analysis of FUNB ongoing and additional validation also being undertaken. Expected completion date is 30 June 2021. Clinic Outcome Forms to be completed after each patient consultation documenting next steps in patient pathway and ensuring appropriate outcome and that patient not lost to follow up. New Clinic Outcome Form has been implemented and if completed correctly for each patient appointment should help to reduce FUNBs. However, recent audit shows poor compliance. Medical records team to continue to work with SSTs to improve compliance. Further audit to be undertaken next month. Regular FUNB reports submitted to the OP Operational Group.
2262		Safety	Velindre Cancer Centre	Accepted	Estates	16/08/2018	03/08/2021		Releasing passenger lift release	In the event of a person being trapped in a lift, they will need to be released in a manner that will not endanger themselves or others.	10	10	5	The lift release key has been removed from Switchboard and has been placed in the Estates key safe to prevent unauthorised use. Staff will not release people or the lift be lowered by manually hand winding unless they have been trained on that lift in accordance with BS 7255 (training has been provided by OTIS). Furthermore there must be at least three members of staff available if the lift is to be lowered by manually hand winding. Persons trapped within a lift are only to be assisted out of a lift if they are within 200mm of a landing. A maintenance contract for lifts at VCC which includes the releasing of persons have been set up with OTIS Lift Company. Any derogation from the above in an emergency situation must be discussed with a senior member of the Estates Management team prior to any action. British Engineering insurance inspections are also undertaken on all lift throughout the Trust.

2261		Safety	Velindre Cancer Centre	Accepted	Pharmacy	10/12/2015	01/12/2021		Lack of electronic prescribing at Teenage Cancer Trust	There is a potential safety risk to Teenagers and Young Adults who are under the care of VCC and TCT and therefore can be admitted to either facility. Currently VCC and TCT have two different systems, VCC operate an e-prescribing system whilst TCT still use paper prescriptions.	16	10	4	Experienced medical and nursing staff - familiar with both processes. TCT staff have access to CANISC but any changes to dose etc. would be via chemocare. The actual dose prescribed will be transferred to Canisc in the next version of chemocare. Pharmacy staff clinically check script(only if access to medical records/prior treatment). Inpatients will receive visit from pharmacist/med recs/clerking but this is not always the case for outpatients so its probably a highter risk for outpatients. Business case is being developed for an all Wales National e-Prescribing solution (single solution). VCC to provide input and implement procured solution. Timescales to be confirmed. 31.08.20 - Working group has been established between VCC Pharmacy, UHW Pharmacy and wider UHW TCT reps since Feb 2020. An interim work around solution has been developed to enable TCT access to VCC ChemoCare and thus for the prescribing of regimens to occur electronically. Development of
2260		Compliance	Velindre Cancer Centre	Accepted	Estates	02/09/2011	03/08/2021		Control of Asbestos at VCC	Working on the infrastructure or fabric of the building and causing the release of asbestos which may endanger patients, staff, visitors and contractors.	15	10	5	Large areas of Asbestos have already been removed from Velindre Cancer Centre. Trust Asbestos Policy and Management Action Plan in place. Supervision on site has received "Management of Asbestos in Building Training" (P405). VCC has and maintains an asbestos register which Estates staff can access. The maintenance ducts have been identified as having asbestos material within them; maintenance staff have been informed not to enter these ducts. Safe systems of work are in place at VCC, all jobs competed by Estates staff are automated through the FACTS system which locates any asbestos in the working area and records them on the job sheet identifying the risk as Level 1, 2, or 3. Estates staff have completed Asbestos Awareness Training within the last 12 months. Estates staff complete Health and Safety training. Contractors are given tool box talks before being allowed to work on site which includes information on Asbestos and known locations. Prior to any

2258		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	17/05/2021	31/12/2021		Medicines at Home Service:	There is a risk that patient pathways and supporting professional procedures and practices (eg SOPs) will not be appropriately or adequately reviewed because of a lack of resource OR that pharmacist attempts to review in the absence of an alternative suitable clinician are clinically insufficient which may lead to patient safety incidents There is a risk to service continuation and sustainability because of limited alternative clinical leadership within pharmacy (or wider SACT and MM Directorate) for the MaH service which may lead to the service needing to be reduced or discontinued with resultant negative impact on SACT and MM capacity and cost savings opportunities. There is a risk to financial sustainability because lack of service resilience may result in the service prematurely ceasing either because of governance issues which could have been avoided OR because of lack of strategic leadership to continue to	16	12	4	Chief Pharmacist and MaH technician have sufficient baseline knowledge of service to enable short to medium term continuation of the CURRENT service provision
2256		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	SACT	26/03/2020	01/11/2021		SACT / Divisional	Reporting on treatment pathway changes As a result of the COVID-19 Pandemic, it is likely that some patients will not be initiated on a new Systemic Anti-cancer Treatment (SACT) treatment regimen, whilst others will have their current SACT regimens deferred or discontinued earlier than originally planned. It is expected that VCC will be requested to report on the number of patients whose treatment pathway has been affected by the COVID-19 Pandemic. Thus, the number of patients that require deferral or cancellation of their SACT or who are not offered / do not accept SACT must be captured. There is a risk that this data will not be captured correctly / adequately which will result in VCC being unable to report the information	16	12	12	A paper providing an overview of the possible methods which are available to capture this data along with the challenges of doing so was submitted to the VCC Clinical Group on 26.03.20 and accepted. Staff guidelines for clinical staff were sent out in the daily Coronavirus Staff Update via e-mail and also made available in the Coronavirus section of the VCC Intranet 1 - All Clinical Staff to be directed to (where appropriate): - utilise the drop down reason code “COVID-19” on ChemoCare, - include COVID-19 in all Canisc annotations and - include “COVID-19” as the “Description” title when utilising the “Other” tab in Canisc 2 - Clinical Audit Department to lead on the capture on this data and to ensure compliance with these recommendations 3 - Recognition that a solution to identify patients whom have not been referred

2255		Financial Sustainability	Velindre Cancer Centre	Accepted	Private Patients	24/02/2021	31/03/2022		Private Patients Debt	An internal audit under in 20/21 reviewed debt management as one of its objectives. A key area requiring attention was the management of aged debtors by the Private Patient Service. The conclusion was that the aged debtors are not monitored or acted upon and there was no action plan in place to improve the situation. Also that there is no liaison between the private patient service and the corporate finance team. Analysis has shown that debtors go back a number of years and include self paying individuals as well as insurance companies. As at the time of submitting this risk the outstanding amount is £328,791.	12	12	4	1. Full review of all debtors in 2017 and 2018 to assess current situation and recommendation for follow up to be provided to Director of Finance. 2. Action plan developed for Trust Audit Committee which will be monitored by weekly meetings. 3. All debtors to be written to by 5th March 2021 providing 14 day payment period requirement. 3. Meeting arranged to discuss automation of process options. 4. Private Patient Manager to benchmark systems with other organisations. 5. Private Patient Manager to review current Standard Operating Procedures (SOP's) to improve current process. 6. Head of Operations and Delivery to work with Deputy Director of Finance to review Trust SOP's and engagement process. 7. Regular meetings with Private Patient Manager and corporate Finance lead to be established.
2254		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Estates	16/06/2020	06/06/2022		Lack of mechanical ventilation at the VCC site (including inpatient ward areas)	This risk has 3 elements – 1. Potential for increased risk of infection due to a lack of mechanical ventilation, 2. Staff and patient discomfort in hot weather due to sub-optimal ventilation, and 3. Breach of Health & Safety regulations and Health & Safety Executive regulation to provide ventilation systems that are sufficient to ensure that high risk patients are protected from exposure to potentially harmful airborne microbiological organisms	12	12	4	Taking each of the three key elements of the risk: 1. Increased potential for infection due to sub-optimal ventilation • Full infection prevention processes are in place, and any patient with suspected infection is cared for in a side room which usually has a window for natural ventilation (in the summer months). 2. Staff and patient discomfort in warm weather due to sub-optimal ventilation • Some mitigations are in place, but further work is required with pace to ensure the well-being of staff and patients during the rest of this summer. • An external specialist will be commissioned to provide recommendations to reduce the heat, and a Task & Finish group has been set up w/c 15/06/20 to develop a hot weather business continuity plan • Further mitigations are being assessed, including use of theatre scrub uniforms for nursing staff and washable cooling blankets and mattresses for patients.

2253	No	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	27/10/2020	01/05/2022		Availability of CANISC System	There is a risk that clinical/patient services across VCC would be critically endangered as a result of the prolonged loss of CANISC, which may lead to significant patient harm and treatment delays due to the lack of availability of critical clinical information for VCC clinical staff. In the event of a catastrophic CANISC system failure, Velindre Cancer Centre would have no electronic patient record and radiotherapy workflow management systems. In this scenario patient care would be seriously compromised, for inpatient admissions and /or outpatient appointments. Electronic access of patient medical histories would not be available or limited to a point in time to guide care decisions. This would lead to the unavailability of clinical information to support decision making. As well as loss of patient administration activities tasks including the booking and processing of outpatient and inpatient activity, clinic lists etc.	15	15	5	Full geographical resilience for CANISC was restored in August 2021 following completion of the migration of national IT services out of the Blaenavon Data Centre (BDC) by DHCW. This means the CANISC service can be 'failed over' to the new 'CDC' data centre in the event of there being issues in the primary 'NDC' data centre. This significantly reduces the risk of the permanent loss of CANISC services. In the event of CANISC becoming unavailable for short periods of time, access to relevant clinical documentation is avialable via alternative systems - e.g. - WCP CANISC Case Note Summary to provide historic record - Chemocare (existing patients) - Welsh Clinical Portal (WCP) for viewing all results, documents and Canisc CaseNote Summary. - WCP is linked to Master Patient Index (MPI) to access patient demographic information - Welsh Results Reporting Service (WRRS) for all VCC radiology reports
2252		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Whole Service	14/09/2020	01/04/2022		Large number of development projects in Radiotherapy	Large number of development project Multiple development and research projects exist There is no single point of oversight or prioritisation of resource There is poor linkage between projects and the risk register or strategic service/ VCC/ Trust priorities. there is a risk that specialist and scarce resources will be required for multiple project simultaneously as a result of which there will be a reduction in patient pathway resource or a delay in the implementation of a number of projects which may lead to patient pathway breaches or delivery delays agreed within the programs Some Physics developments delayed as redirected resource into paperless planning project and increasing resilience in treatment planning. This enabled staff to work from home and prepared for potential staff absences / future increase in demand	20	15	10	Prioritisation process underway. Program to support delivery Medical Physics and RT Ongoing review of major projects. Core team with resilience approach identified to allow scientists back to project work Program plan for Radiation Services being developed will require resourcing input from IRS nVCC and DHCR

2251		Compliance	Velindre Cancer Centre	Accepted	Medical Physics (previously Radiotherapy Physics)	18/03/2016	30/09/2021		XVI imaging termination faults resulting in repeat acquisitions	There is a risk that the patient will require an additional CBCT scan to confirm treatment position as a result of a known fault with XVI which may lead to additional patient imaging dose. Under new IRMER guidance if 3 scans are required to achieve 1 usable dataset this becomes reportable. This fault is known UK wide issue. When using XVI CBCT (Elekta only), faults are occurring intermittently during the image acquisition. This is resulting in repeat image acquisitions needed which increases the overall dose the patient is receiving from imaging. It is also worth noting that these scans usually terminate part-way into the scan. If a full additional scan is acquired the patient will receive a maximum of 2 - 20 mGy additional dose, which is <0.1% of a typical treatment dose. CBCT imaging is essential to verify correct patient position during treatment, ensuring the radiotherapy treatment targets the tumour and spares Organs at Risk and critical structures. This is a known issue nationally and Public Health England and HIW are aware	15	12	9	1. If a patient is having a routine offline XVI CBCT and the unit faults during acquisition attempts should be made to clear the fault and carry on. If the radiographers cannot clear the fault themselves the engineers should be contacted for advice. One further attempt at a full scan is permitted. If this fails then the CBCT should be repeated on the next fraction on an alternate unit. A Datix should be completed for all failed scans that cannot be continued from the point of failure. Scans that can be continued should still be recorded in the machine log. 2. For online scans the same as above applies but if a second scan fails then the patient should be moved to an alternate machine prior to treatment. 3. When a patient receives a total of 2 extra partial scans due to faults, then a superintendent must be informed, and the patient must be moved by the radiographers on-set to another LA for the remaining imaging fractions. 4. All partial scans to be recorded on the imaging form. 5. Radiotherapyl Physics and the treatment superintendents must be
2249		Financial Sustainability	Velindre Cancer Centre	Accepted	Operational Services	27/02/2020	20/12/2021		Risk of service disruption due to number of posts funded by soft monies leading to financial instabiity,recruitment difficultie	A high proportion of VCC workforce are funded via 'soft monies' from the Trust Charity or Third Sector. This leads to risks around service continuity, recruitment and retention and staff wellbeing. It also poses a financial and reputational risk for the Trust should funding be ceased. For 20/21 there is approximately £2.8 million of charity/3rd sector funding which is supporting service delivery.	12	12	4	Funding ending in the next year to be included in cost pressures for 2020/21. Review posts funded externally to establish: Number of posts, length of funding, contribution to service, and contractual position of postholder. Establish Financial contingency. Through the scrutiny process ensure future risks are considered for all new and extended posts. Prioritise work in order of funding stream end date
2248	No	Safety	Velindre Cancer Centre	Accepted	Nursing	29/10/2020	31/01/2022		There is a risk that non-compliance with COVID-19 Health Regulations may place staff and patients at higher risk of infection	There is a risk a risk that that non-compliance with the Health Protection (Coronavirus Restriction Wales) Regulations 2020 could place patients and staff (FFW, CIU) at increased risk of infection and contracting COVID-19, resulting in illness. Regulation 7A of the Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020 dictates: - that all reasonable steps have been taken for staff to work from home; - when they are in work environment, all reasonable steps have been taken to maintain a 2m distance; - and where people cannot be 2m apart, everything practical done to manage transmission risk.	16	12	12	Update 10/12/21 - Regular updates and guidance given by IPC Team to all staff to remind them of IPC requirements. Enhanced cleaning still in place; social distancing measures remain in place; cleaning wipes and sanitiser freely available along with face masks. Mitigation -Cleaning regime reviewed as part of changes made, e.g. all ward staff including visiting staff wearing suitable PPE (e.g. cleaners, admin, pharmacy, RT etc) - Hand Sanitiser stations installed - Hand washing posters at sinks - Sterilising materials, wipes, spray etc available for all staff - Enhanced hand washing regime - Staff who can work from home being assessed and if applicable currently doing so - Care taken to manage 2m space where applicable - Social distancing posters - If appropriate reduce amount of staff in working area where applicable. The FFW offices, are areas where social distancing is unable to be maintained for hand overs etc PPE is provided for use

2245		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	12/04/2019	31/12/2021		Service impact of delay in equipment replacement	Service impact of delay in equipment replacement Current provisions for Radiotherapy Services at VCC are based on the assumption that a new Cancer Centre and associated Satellite Centre will be clinical by 2021/22. Delays on these projects will impact negatively on the Radiotherapy Department at VCC. Linear Accelerators have a recommended clinical life of 10 years. In 2019, there are currently 3 (out of 8 (38%)) linacs aged 10 years or above. In 2021 there are currently 5 (out of 8 (62%)) linacs aged 10 years or above. Identified hazards are to be found in the risk assessment attached as a document.	15	12	3	Timely / effective communication with Commissioners / Government re. Linac life, performance etc. Older linacs can receive deep services / upgrades with the intention of extending clinical life. Ability to add functions / services to older linacs / equipment such as RPM / DIBH make this viable. Uptime is maximised by good in-house engineering support. Engineers are very experienced at VCC. Service contracts allow access to Manufacturer's engineers when required. Complaints procedure in case of issues with quality of service. Gaps procedure assist with direction in times of breakdown. Experience and skill of staff allow effective dealing with delays and patient issues. RCR guidelines guide protocols for acceptable prolongation of treatment courses prior to compensation (NB. Latest update suggests that standard 3-week course of breast treatment should ideally not be prolonged for more than 2 days). Regular update of staff from
2244		Workforce and OD	Velindre Cancer Centre	Accepted	Medical Physics (previously Radiotherapy Physics)	14/09/2020	12/02/2021		Senior Management Capacity	Senior Med Physics Management Capacity is under pressure due to some staff being utilised on IRS Multiple major programmes pull senior staff away from service delivery. COVID exacerbates the situation Separation between service and major programme means there is a loss of continuity and ownership	12	12	4	Deputies for the programs to be identified without affecting service delivery
2243			Velindre Cancer Centre	Accepted	SACT	30/06/2021	15/12/2021		SACT staff turnover	There is a risk that SACT Daycase may not be able to deliver care at the current level as a result of staff turnover which may lead to SACT reducing capacity at the SACT Daycase Unit which will impact on patient care and patient experience.	16	12	3	Senior SACT management working in the numbers Clinical trainer working alongside junior staff closed mobile unit on MONDAY Senior staff working on helpline Deputy Director of Nursing undertaking a review on the turnover/retention and education pathways
2239		Safety	Velindre Cancer Centre	Accepted	SACT	06/06/2012	28/01/2022		Pharmacy Stores – inadequate space	There is an increased risk of accidents and injuries to staff and a security of product issue, due to inadequate space in the pharmacy stores, which is leading to products being stored outside official areas.	12	12	9	Staff are trained in manual handling. Regular contact with VCC Manual Handling Advisor. Staff are partially involved in managing risks. 25.06.19 - new aseptic unit expected to be clinically operational September 2019 which will give additional storage space and allow reconfiguration of current stores. Refurbishment of old aseptic unit planned October 2019 which will allow further reconfiguration of stores. Ongoing work between pharmacy and nursing to identify nursing consumables and non-medical dressings to be relocated to nursing stores. 20.01.2020 updated by RWD- new aseptic unit expected to be clinically operational February 2020 which will give additional storage space and allow reconfiguration of current stores. Refurbishment of old aseptic unit planned October 2019 which will allow further reconfiguration of stores. Ongoing work between pharmacy and nursing to identify nursing consumables and non- medical dressings to be

2236	No	Quality	Velindre Cancer Centre	Accepted	Operational Services	08/04/2019	03/01/2022		There is a risk of poor patient experience as a result of insufficent space and poor environment	The design of the OPD department is not fit for purpose, there is a lack of available accommodation, insufficient space in waiting area, the reception desk is not ideally placed and the fabric of the area is in poor condition.	15	12	12	1. Nurse 'rounding' in place to monitor patients on regular basis 2. External 'canopy' waiting area 3. Information provided explaining visiting restrictions but process in place to call relatives into consultation if appropriate 4. High level of virtual consultations 40-50% 5. Clinic planning and preparation undertaken daily 6. Task and Finish Group to lead repatriation of OPD and phlebotomy to HB's 7. Service improvement programme to reduce waiting times, improve experience etc 8. Appointment system implemented for phlebotomy appointments
2229		Workforce and OD	Velindre Cancer Centre	Accepted	Operational Services	12/03/2019	24/01/2022		Risk to timely communication/engagement activities as a result of dedicated resource leading to low morale, reputational damage	There is a risk that positive communications are not distributed in a timely manner as a result of lack of dedicated VCC resource therefore positive communication is not provided in a timely manner to staff or externally. VCC has no dedicated specialist communication resource to support the patient and staff experience. This limits the processes that can be developed and also poses a risk to media handling. There is no dedicated support to develop social media policy or channels which limits communication options.	12	12	4	Resource increased within corporate communications and TCS teams.
2224		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Operational Services	07/11/2019	12/01/2022		Demand for services outstripping capacity	Demand for services outstripping current capacity resulting in patients not being seen in a timely manner and waiting time breaches. Also results in overbooked clinics which are extremely busy. In addition, many of the outreach clinics continue to be run from VCC which is adding to the pressure on clinic rooms.	16	12	16	UPDATE June 21 - Risk rating increased to reflect current situation. Increasing referrals are leading to an increase in outpatient attendances resulting in very busy clinics. Continue with planning for any surge in activity due to cancer backlog and latent demand from health boards is being undertaken by VCC. Continue with weekly monitoring of outpatient referrals and activity. Progress with the work of the Demand Modelling group being led by the BI team. Continue to have discussions with health boards re. outreach clinics and likely demand for services.
2223		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Operational Services	21/07/2020	12/01/2022		Delay in re-starting outreach activity	The delay in re-starting outreach activity which is as a result of the COVID-19 pandemic, is impacting on outpatients resources and the availability of clinic rooms in VCC. This is because all outreach services have been repatriated to the cancer centre for the duration of the COVID-19 pandemic.	12	12	12	UPDATE June 21 - Discussions to repatriate outpatients clinics continue with health boards. Previously agreement from ABUHB to re-start outreach clinics in Nevill Hall but subsequently notified that space is not available, although not Royal Gwent. VCC group established to manage repatriation of clinics and SACT to NHH. Continue with ongoing discussions with other HBs as this remains a priority for VCC. SSTs have been asked to review all their clinics and highlight priority clinics for repatriation. Undertake surge planning and discuss impact with health boards

2222		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Nursing	07/11/2017	31/07/2021		Loss of CANISC - compromise patient care	There is a risk that as Canisc is an 'end of life' system, it could fail which could compromise patient care. It could mean that some patients cannot be seen in clinic or some would experience long delays. This can lead to increased patient anxiety, frustration and stress for staff, overcrowding in waiting areas and a possible delay in prescribing chemotherapy.	16	12	12	Update June 2021 – DH&CR project continues at pace which includes plans to replace CANISC with WPAS. Regular meetings taking place to review OPD processes and clinics. CANISC BCP remains in place. Implementation of the Document Management Solution – copy of correspondence available electronically on local infrastructure. Correspondence viewable in the Welsh Clinical Portal. Correspondence sent to the GP electronically (via WCCG). Welsh Clinical Portal to link to the Master Patient Index – in the event of Canisc being unavailable this version of the WCP would be invoked enabling access to documents, test results and the GP Summary. Authorised staff members have direct access to Synapse (local infrastructure) – VCC radiology images and reports available to view. Aria and Mosaiq not reliant on Canisc – Radiotherapy treatment can continue in the event of a Canisc outage. ChemoCare decoupled from Canisc and held of local infrastructure – SACT prescribing, dispensing and delivery can
2221		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	24/02/2021	29/11/2021		Digital Health & Care Record DHCR019(R) - Clinical Coding Copy Functionality within WPAS	DHCR019(R) - Clinical coding require a 'Copy Coding Functionality' within WPAS. Currently within Canisc VCC Clinical Coding staff are able to choose an option to 'copy exact coding to all linked Radiotherapy (RT) Regular Day Admissions (in same sequence of admissions)'. This means that if a patient has received 10 episodes of radiotherapy the coder can code the first episode and then click the copy function to copy to the other 9 episodes. This saves the coder time and ensures the accuracy of the coding. This functionality is not available within WPAS; therefore it is requested that the functionality be developed. There is a risk that NWIS are unable to deliver an exact replica of the functionality within the timescales - there is also a prerequisite on the Radiotherapy Admissions work completing and the eIRMER development. This could affect the implementation timescales. DHCW confirmed that they can replicate	16	16	12	The proposed interim solution will enable 'manual selection instead of automated selection and copy'. This will enable the user to select multiple episodes across multiple admissions, within a single patient's record, and copy the coding from the 'coded' episode, to all other episodes selected. The user will have to verify that they want to complete this transaction to ensure the correct admissions is selected

2220		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Medical Physics (previously Radiotherapy Physics)	07/11/2018	31/12/2021		Treatment Planning System End of Life	There is a risk that some patient treatment plans cannot be completed as a result of the OMP treatment planning system breaking down and being past end of life, which may lead to inability to plan / treat sites not transferred from OMP. The Oncentra MasterPlan treatment planning system is end of life and is no longer be supported by the manufacturer. A replacement treatment planning system, RayStation, is being commissioned but due to understaffing within physics, and a change of priorities due to Covid, commissioning is taking longer than initially estimated. Should a catastrophic failure of OMP occur at this point in time (March 2021) the centre will be without a planning system for the Varian 2100 machines (breast patients), and 10 MV treatments on Truebeam and Elekta machines. There is a risk that the existing treatment system will fail and without the implementation and alternative no planning system for all breast patients to be treated	15	15	1	Most physics developments are on hold to redirect resource to the commissioning of RayStation. Commissioning plan is in place. Outsourcing contract in place and being utilized with Rutherford Detailed contingency plan is being worked through
2217		Workforce and OD	Velindre Cancer Centre	Accepted	Medics	14/09/2020	01/12/2021		Medical Capacity for RT Planning in Job Plans	Medical time for RT Planning within job plans is not efficient, timely or in many cases, sufficient, particularly with the RCR requirement for peer review. Any time allocated may not be protected due to the increase in clinical admin work and email requests. Outlining delays have a knock-on impact on the pathway which has the potential to delay the patient's treatment start date and increase breaches.	4	15	2	Review job plans to ensure adequate time available. Job Planning is ongoing annual process however it is not always possible to allocate time for RT Planning into the job plan without dropping alternative work. Each case is individually assessed to factor RT Planning into job plans.
2213		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	09/07/2018	01/05/2022		VCC Phone System - External Phone Lines	There is a risk that external telephony services in VCC may be disrupted as a result of the ongoing use of the 'end of life' PBX gateway ISDN30 line, which may lead to the inability to make inbound and outbound external calls, resulting in significant disruption to clinical / patient and administrative services.	16	12	4	22 phone lines are strategically placed around VCC site to enable dialling to public telephones in the event that an ISDN30 line is lost. Discussion with supplier commenced. Capital funding to be secured for delivery of resilient SIP.
2211		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	09/10/2020	29/11/2021		Digital Health & Care Record DHCR004(R) - Requirements for Standardisation process redesign & agreed Ways of Working	Requirements for standardisation, process redesign and agreed Ways of Working - Business Change The scope of the deliverables for the workstreams will change after being signed off and planned and may cause delays. There is a risk that without an element of standardisation; process redesign and agreed ways of working; system configuration, testing and training becomes very complicated and time consuming.	16	16	12	Ways of Working sessions to be held. Key advocates for change, standardisation and process redesign to be involved in the project Project Governance - Workstreams will be established to ensure key decisions are made with all involved in a timely manner required by the project. SMT and Clinical Lead support on standardisation of Ways of Working

2206		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	09/10/2020	29/11/2021		Digital Health & Care Record DHCR003(R) - IM&T Dept - Covid-19 Pandemic	DHCR003(R) - Could impact on key project team members capacity due to service requirements being prioritised, childcare needs, the need to self-isolate etc. The ongoing impact of the Covid 19 outbreak continues to have a significant impact of staff in terms of their well-being, their availability and their ability to absorb new ways of working and new systems within an already stretched environment. Also, additional clinical pressures/ demand on; clinics, inpatient activity, treatments and the presentation of potentially sicker patients, resulting from the impact of COVID19.	20	12	9	Following guidance from VUNHST & Government Project team are all enabled to work from home as required. Early engagement and communication plan in place to keep staff updated and included in the process. Departmental leads being identified to ensure that all departments have a voice at the table and a mechanism to feed in their requirements. DHCR producing Contingency plans as part of COVID-19 response. Canisc will be moved as part of the data centre project, if this failed the contingency would be a single instance of Canisc running in Newport data centre.
2205		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	14/09/2020	31/01/2022		CANISC failure	Currently the CANISC electronic IR(ME)R form is the only way for the Oncologist to request a CT simulation scan and subsequent radiotherapy treatment for all patients bar emergencies. It is also the system used to manage the complex radiotherapy pre-treatment workflow and to document and authorise the detailed dose information for a patient plan prior to treatment. This documentation and authorisation is required under the IR(ME)R 2017 regulations. If CANISC is unavailable, there is no “fall-back” method for the above tasks. Business Intelligence (BI) data is also sourced from the electronic IR(ME)R form in CANISC, the loss of which will reduce the ability for BI reporting, forecasting and modelling. CANISC will no longer be available from September 2021, with the long-term IR(ME)R form replacement (part of the IRS) not being fully procured and in-house until around this time. CANISC will no longer be available from	25	15	9	Engagement with NWIS & DCHR to develop MVP ongoing. DCHR-led project underway. Initial option appraisal highlighted high likelihood of gap between CANISC and OIS; several discussions occurring to confirm this and identify optimal bridging solution. Approved Design in place for WCP IRMER as an interim solution - this now is subject to acceptance testing of the software delivery by VCC service leads
2203		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Digital Services	12/01/2021	29/11/2021		Digital Health & Care Record DHCR013(R) - Accelerated Timelines of the DHCR Programme	Due to the accelerated timelines of the DH&CR Programme, the data migration phase is having to be compressed from 18 months to 6 months. Data Migration Phase 1 (Patient Demographics and casenotes) and Phase 2 (Referrals, activity, Clinics, pathways and waiting lists) both need to be completed by prior to UAT testing which is due to commence in July 2021. There is a risk that any delay to these data migration activities could have a direct impact on the quality of the patient data migrated from Canisc into WPAS as there will be no time to review and cleanse the data prior. There is also a risk that any delay to the data migration activities will have a direct impact on the WPAS implementation date which may lead to the Service having to rely on an unstable and unsupported Canisc instance for a longer period of time.	16	16	8	Data Migration Phase 1 near completion and there are dedicated WPAS team resources working hard to complete all phase 2 activities by the end of April 2021, in line with the current DH&CR Project Plan which has been approved by the DH&CR Project Board.

2202		Workforce and OD	Velindre Cancer Centre	Accepted	Medics	23/02/2021	01/12/2021		Consultant cover for long term absences	Two consultants will be taking Maternity Leave in 2021 in Urology and Breast tumour sites. One Consultant is planning a sabbatical in Spring 2022. One Consultant on Long Term Sick Covid related from Mar 2020.	20	12	4	The Directorate has employed a Consultant for a 1 year post to cover the Urology gap for Mat Leave in 2021 but may require extending the contract to Mid 2022 depending on how long the Consultant will be off on Mat Leave and also to cover the sabbatical in 2022. An additional temporary consultant will be required to cover the breast sessions for the 2nd Mat Leave.
2200		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	01/05/2011	31/12/2021		Radiotherapy Capacity	Availability of sufficient radiotherapy capacity within available financial resource affects achievement against national cancer standards. Patients may not be treated to optimum treatment timescales, which may affect the overall patient experience and lead to poorer outcomes. 2/7/19 update Hazards broken down into safety / quality and service sustainability sections. Narrative clarified – risks defined (PJ). This will be linked to Risk 2245 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix. 23/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted to a maximum due to safe staffing, skills mix, and the age and configuration of the fleet. Any delay in the development of the	20	20	6	Ongoing monitoring of capacity and demand Ongoing monitoring of breaches of waiting times targets Reports and business cases have been prepared Radiotherapy strategy Discussion underway regarding future radiotherapy configuration through the TCS programme Extended working hours are in place on the treatment machines and in many other areas of the service Agency radiographers in place to support additional hours Updated 23/5/19 (PJ) Ongoing monitoring of capacity, demand breaches and waiting times targets. Extended working hours are in place on the treatment machines and in many other areas of service. Agency Radiographers are in place to support additional hours. Changes made to radiotherapy booking processes, and staff flexibility used to maximise use of resources. Project to be commenced to address
2198		Financial Sustainability	Velindre Cancer Centre	Accepted	Operational Services	29/12/2017	13/12/2021		VCC mayface financial loss, legal action, inaequate service provision as a result of no coordinated system for SLAs, contracts	VCC has numerous contacts and SLA's for services delivered by NHS organisations and external companies. To manage such legal agreements it is crucial to have robust governance structures for the development, management, monitoring and renewal of such documents. There are a lack of processes, clarity regarding responsibility regarding responsibility, management etc and a varied level of monitoring.	16	16	6	Specialist procedure advice via NWSSP Agreement for planning team to take ownership (delayed due to COVID) VCC Planning team to take responsibility for establishing database and monitoring mechanism
2196		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	14/09/2020	01/12/2021		Radiotherapy Department - COVID Isolation Impact	COVID Isolation Impact Staff isolation as a result of coming in to contact with a COVID positive person, exhibiting COVID symptoms or receiving a COVID positive test result will affect the capacity (Linac & Pre-Treatment hours) of the radiotherapy department as the majority of staff are patient facing and are unable to work from home. Resulting in the need to contract the radiotherapy service.	16	16	4	Ability to work from home with relevant IT equipment on completion of DSE risk assessment Isolations rules to be reviewed regularly. 7/5/2021 – risk reviewed by HP & CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service. 1/11/2021 – risk reviewed by CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service.

2193		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Nuclear Medicine	05/02/2021	01/04/2022		Medical Physics Expert cover for Molecular Radiotherapy (Nuclear Medicine)	Medical Physics Experts (MPEs) for Nuclear Medicine. This risk combines 8438 (submitted by S Hooper – MPE cover for clinical trials) and 15684 (submitted by M Talboys – Ra223 service) on the current risk register and has been expanded to encompass new developments on the immediate horizon. There is a significant risk is that Velindre Cancer Centre will not be in a position to safely and sustainably offer the Molecular Radiotherapy (MRT) demand, likely to be required in the next 12-18 months. This arises because of a lack of experienced Medical Physics Experts (MPEs), the timescales over which the implementation of new MRTs may be required, the predicted increase in workload and the anticipated number of other significant developments which will lead to not being able to implement MRT MPE cover within Nuclear Medicine for MRT has been extremely stretched for a number of years	20	16	2	Current control measures include:- Not participating in clinical trials involving MRT Not implementing any new MRT until a safe, sustainable service can be provided Organising workload to minimise the impact of a lack of MPE back-up. Expectation to date has been to ask C&V Medical Physics to provide any additional MPE cover. However, the depth of MPE cover has been critically eroded over the years and recent resignations mean the current position is there will be only 2.5 WTE physicists left by the end of April (only 2.0 WTE being MPEs). One of those MPE is already providing 1 WTE support to VCC under an SLA for over >30 years. This leave 1.0 WTE MPE at C&V. (C&V provides MPE support to other HB as well as its own).
2191		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	14/09/2020	31/01/2022		Inability to meet COSC / SCP targets	Inefficiencies in current pre-treatment pathways and failure to meet agreed timescales - link to breach report against time to treat targets.	20	20	4	Workforce requirements highlighted Service improvement project to be initiated
2190		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Radiotherapy Services	14/09/2020	31/03/2022		BI Support for reporting of Breaches	BI Support for reporting There is a risk that lack of high quality data informing in real time key activity (demand/ capacity) Key data inputs (RTDS) are done manually Different staff groups only understand their own systems. Resulting in a lack of ability to accurately forecast and model future demand for services which may impact on accurate capacity planning for the scheduling of patient pathways	16	16	10	Large amount of BI is occurring, with better understanding of RT BI and complexity of internal RT processes
2188		Compliance	Velindre Cancer Centre	Accepted	Operational Services	18/04/2018	24/01/2022		There is a risk that services cannot be expanded to meet demand as a result of lack of accommodation which may affect service de	Lack of physical space to accommodate the current service requirements, statutory building note requirements, health and safety standards and other legal requirements at Velindre Cancer Centre. This risk affects all areas within VCC. A number of internal and external audits have demonstrated a significant lack of physical space within all areas of VCC. COVID 19 pandemic has further reduced available site capacity by 40-50%. Increased provision of clinical services and workforce requiring additional space. Requirement for Digital Programme Team to return to VCC site in view of DHCR replacement programme, testing and training requirements etc.	12	12	6	1. Ongoing review of current accommodation to ensure best use and maximisation. 2. Review service models and the balance between on site and outreach services to make best use of all resources. 3. Implement changes in working practices where appropriate (e.g. working from home, extend the working day) 4. Office sharing principles reviewed in light of COVID19 which has led to reduction in available office accommodation due to 2m rule. 7. Open plan and flexible working. 8. Additional space within CRW to be utilised as a temporary measure for Digital Programme Team as part of DHCR Programme. 9. Non-critical staff relocated from VCC site or WFH under COVID principles. 10. Capital bids placed and timelines produced. 11. Business case submitted to WG for Fire Improvement work. 12. Business case being produced for ventilation improvements in clinical areas

2187		Performance and Service Sustainability	Velindre Cancer Centre	Accepted	Medical Physics (previously Radiotherapy Physics)	14/09/2020	31/12/2021		Radiotherapy Physics Staffing	NB - see Progress Notes for latest update 13/09/21 The recently received ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Head of Medical Physics retired in November 2019. This post has not been replaced and, consequently, approximately 0.5 WTE of management or Medical Physics Expert (MPE) tasks have been absorbed by the department at the detriment to other tasks as described below. Senior staff are also working significantly over their contracted hours, which can be evidenced as time owed in lieu. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are	25	15	5	Medical Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. Recruitment is underway to mitigate this risk, currently at 15, as this resource will cover the business critical programmes. This is subject to dynamic risk
2185		Safety	Velindre Cancer Centre	Accepted	Medical Physics (previously Radiotherapy Physics)	14/09/2020	31/05/2021		Delination Risk treatment delay (16284)	There is a risk of physics planning rework and patient delay as a result of errors in tumour volume delineation / margin growth, which may lead to a reduction in physics capacity and inability to meet planning targets. These errors are generally not picked up at medic peer review or during the physics planning process but by more experienced clinical scientists at final physics check, often the day before treatment. There is a lower risk that errors are missed at physics check and make their way to treatment. A number of Datix incidents have been attributed to target and organ at risk delineation errors. These incidents are generally identified at final physics check and so the effect is treatment delay and repeat work (planning) within physics. However, these errors would be classed as near misses as the errors were not detected during the medic peer review process, approval, or at the physics planning stages. Action is required to ensure these errors do not propagate to	15	15	9	Discussions at the RMG quality focused meeting to ensure the medical workforce are aware of the issues and to enable discussions and learning within SSTs. Medic peer review processes (for some treatment sites). A physics quality improvement project has been initiated to ensure effective multidisciplinary learning. This should reduce the requirement to replan due to errors not being detected until the final checking stages, and should also reduce the likelihood of a radiotherapy mis-treatment. Further controls required – a Datix medic representative to ensure joint investigations.

APPENDIX

In light of current changing circumstances regarding Covid, a summary is provided below of current assessments of potential risks and issues emerging from Silver and Gold structures. The below relates to potential risks and issues with a direct or indirect impact on the response to Covid.

Risk Type	ID	Division	Title	Initial View of Inherent Risk Score	Key Controls	Initial View of Residual Risk Score	Risk Trend	Action Plan
Safety	*Datix record being completed*	Trust-Wide	Changing profile of Covid-19 infection risk, impacting our patients, donors and staff	20 (as at late December)	- Re-establishing command structure - Clinical governance strengthened, with establishment of Strategic Clinical Advisory Group at Gold level and Clinical Development Group at Silver level - Covid Cell established - Decision making framework refreshed, approved by Trust Board and reinstated - Changes to Board and Executive Meeting Structure, including increase frequency of Quality, Safety & Performance Committee	12	Stable ↓ *(reducing from 20 to 12)*	- Finalise operational review of Clinical Principles, including trigger points – governed through Gold 13.12.2022 via: - Strategic clinical advisory group - WBS risks based social distancing paper to be completed and approved
Performance and Service Sustainability	*Datix record being completed*	Velindre Cancer Centre	Risk that Covid-19 related absences for staff could significantly impact on ability to provide core SACT and Radiotherapy Services and Outpatient reviews (including new	20 (early Jan)	- SACT staffing - realignment from wards, senior staff deployed, RD&I capacity utilised in line with the agreed impact assessment to ensure the R&D/Trials service is able to also fulfil Welsh Government guidance to continue research delivery; increased virtual appointments, further staffing	16	Decreasing in score ↓	- Further focus on demand and capacity modelling, linked to current action plan – subject to Gold review 19th January

			patients, follow-ups and urgent problems) in the Velindre Cancer Centre		contingency agreed and will be implemented if further SACT nursing staff absences occur - Radiotherapy - major limitations on capacity due to reduction in workforce but maintaining service with increase in breaches with prioritisation based on clinical need; Changes made to Prostate pathway based on agreed framework; maximising third party provision.			
Performance and Service Sustainability	*Datix record being completed*	Welsh Blood Service	Risk that stock level risks in January resulted in Blue Alert being issued, could have impact on the ability of the Welsh Blood Service to effectively service the health system	16 (early Jan)	- Various actions have resulted in a significant increase in stock levels currently, with the expectation of further improvements in coming weeks with additional Saturday clinics being added	12	Decreasing in score ↓	- Further review of Blue Alert level w/c 17th January
Safety	*Datix record being completed*	Velindre Cancer Centre	Risk that current regulations in Wales regarding isolation has impacted on patients being able to commence treatment	16	- Research underway into practices nationally conducted via Silver Command for reporting into Gold	16	Stable ↔	- Finalise recommendation for Gold decision, as appropriate, on any changes
Workforce and Organisational Development	*Datix record being completed*	Trust-wide	Risk that changes to working from home policy for the Trust, as a result of changes to	12	- Clear communications on reasons for changes required - Consistent approach for all staff in similar roles across Trust	8	Decreasing in score ↓	- Decision on approach from end January following expected further changes to national alert levels

			regulation, linked to change to national alert level change in late December, could impact on the well-being of impacted staff		- Well-being resources clarified further			

TRUST BOARD

TRUST ASSURANCE FRAMEWORK

DATE OF MEETING	27 January 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Strategic Development Committee	09/12/2021	**NOTED**
Audit Committee	11/01/2022	**NOTED**

1. SITUATION

The purpose of this paper is to provide the Trust Board with an update on the further development of the Trust Assurance Framework (TAF), together with the ongoing work to support its continued development, articulation and operationalisation within the Velindre University NHS Trust.

2. BACKGROUND

The Trust Board received the first iteration of the populated Trust Assurance Framework at its September 2021 meeting, which outlined the high level principal risks that may threaten the achievement of the organisation's strategic objectives and intent. As previously indicated there is not expected to be significant movement in the articulation of these risks in the short-term, instead these will be reviewed and evolved in line with the Trust's Integrated Medium Term Planning cycle or in response to significant external changes.

However, in working through the detail in September 2021, the Executive Leads for **Demand & Capacity** and **Quality & Safety** highlighted that their respective strategic risks required further articulation and reframing to more accurately reflect some of the recent activity to support continuous improvement underway across their service areas. In addition, work was to be initiated to support the articulation of the **Organisational Culture** strategic risk, key to which was the impending approval and adoption of the Trust People Strategy and its three themes of a Healthy and Engaged Workforce, a Skilled and Developed Workforce and a Planned and Sustained Workforce.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Revised Reporting Mechanism

There have been a number of key developments to the Trust Assurance Framework since its first iteration in September 2021, the first of which includes a revised reporting mechanism. The agreed template for the Trust Assurance Framework was initially implemented via Microsoft Word as the chosen platform. However, this meant that any coding to enable subsequent analysis and the development of future dashboard reporting could not be effectively achieved. As such, the previously agreed information captured in the Trust Assurance Framework has now been reformatted and transferred to Microsoft Excel. This will ensure plans to develop dashboard reporting by Quarter 1 of 2022/23 can be realised.

A number of further enhancements have also been implemented as part of the move to a different platform, via active engagement with end users to improve user application. This includes increased automation and drop down menu facility. In addition, all definition criteria referenced in the overarching Trust Risk Assurance document have been compiled into a more easily accessible '**TAF Definitions'** tab provided on the Trust Assurance Framework. Furthermore, all ten agreed strategic risks have been collated together on the Trust Assurance Framework (marked 1-10), this will enable end users to more readily reference each of the individual strategic risks for transparency and to aid consistency of reporting.

3.2 Further Articulation of Strategic Risks

Since September 2021, the Executive lead for the **Demand & Capacity** strategic risk has undertaken a holistic review of the detail captured to facilitate a fuller assessment of the key controls currently in place together with any gaps in assurance and actions required. This is included at ***Appendix 1***, via ***TAB 01***.

The Executive Lead for the **Quality & Safety** strategic risk has also reframed the articulation of this risk to reflect the developments in framework approach in recent months for Quality & Safety. In addition, the articulation of the controls and assurance mechanisms described have been further enhanced, the detail for which is included at ***Appendix 1,*** via ***TAB 06***.

The **Organisational Culture** strategic risk has also now undergone its first iteration and is included at ***Appendix 1***, via ***TAB 04***. This is to be worked up further to reflect the many facets of work that the Trust has underway or in development that will ultimately effect the culture of the organisation and the way in which it works as a whole to effectively deliver services and achieve its ambitions. As outlined above, key to this will be the approval of the Trust People Strategy anticipated to be in place by the end of this calendar year.

The **Organisational Change / Strategic Execution** risk remains in the early stages of development reflecting the emerging Trust wide strategy for 2032, this was anticipated to be included in the further developed Trust Assurance Framework and inserted at ***TAB 05*** in readiness for presentation to the January 2022 Trust Board. However, due to the emergence of the prevalence of the Omicron variant and increased demands on Trust officers to respond to the escalating position, this has not been able to be progressed at this point in time. This will now be progressed before the end of March 2022 subject to the continued prevalence of the Omicron variant and business continuity arrangements currently in place.

3.3 Next Steps in Development

i. Document Control & Supporting Evidence

To help ensure that the Trust Assurance Framework remains a live tool this is to be made available to all end users via Microsoft Teams. This will enable all updates to be made in 'real' time and ensure that all users have full visibility of the most up to date and correct version of the Trust Assurance Framework.

A file structure will also be created within this shared Microsoft Team folder to save all supporting evidence referenced within the populated Trust Assurance Framework, to aid transparency and completeness.

ii. Trends in Assurance

By the end of Quarter 4, a graphical representation will be provided to record and detail any **Trends in Assurance** for each of the strategic risks. This will signal just one of the early developments planned to move to increased utilisation of dashboard reporting functionality.

iii. Hierarchy of Risks

At the January 2022 Audit Committee it was proposed that a holistic view of which risks feed up into the overarching strategic risks is developed for additional assurance so that the relationship between these is fully understood with further scrutiny applied as required. This is to be considered within the wider risk management framework / risk reporting arrangements and how this can be developed.

iv. Board Development Session

Also at the January 2022 Audit Committee it was proposed that a Board Development session be utilised to support a general discussion with Board members to gain further clarity around what we consider to be our Strategic Priorities and Objectives. This will help inform a wider collective view of what we consider to be our Strategic Risks and then also support what methodology we then want to apply and utilise in the further development and understanding the relationships between what risks are contributing to our strategic risks, what assurance we have around this, where that assurance is coming from and the mitigation plans in place. This is to be taken forward as part of the Board Development Programme for 2022/23.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes
	Please refer to ***Appendix 1*** for relevant details.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Velindre University NHS Trust Board is asked to:

I. **NOTE** the progress to date, and **DISCUSS / REVIEW** the next iteration of the Trust Assurance Framework included at ***Appendix 1***.

II. **NOTE** the next steps in the development pathway to support further operationalisation of the Trust Assurance Framework.

TAF DEFINITIONS

RISK DESCRIPTORS			
RISK NUMBER	**RISK THEME/TITLE**	**DRAFT RISK DESCRIPTION**	**RISK OWNER**
01	**Demand and Capacity**	Failure to adequately model demand and capacity and service plan effectively, results in failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control.	**Cath O'Brien** Chief Operating Officer
02	**Partnership Working / Stakeholder Engagement**	Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.	**Carl James** Director of Strategic Transformation, Planning & Digital,
03	**Workforce Planning**	Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.	**Sarah Morley** Executive Director of OD and Workforce
04	**Organisational Culture**	The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.	**Sarah Morley** Executive Director of OD and Workforce
05	**Organisational change / 'strategic execution risk'**	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.	**Carl James** Director of Strategic Transformation, Planning & Digital,
06	**Quality & Safety**	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust traingulated datasets and to systematically demostrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.	**Nicola Williams** Executive Director of Nursing, Allied Health Professionals & Health Scientists
07	**Digital transformation - failure to embrace new technology**	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.	**Carl James** Director of Strategic Transformation, Planning & Digital,
08	**Trust Financial Investmnet Risk**	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical practices and thus ensure appropriate funding mechanisms are in place and agreed.	**Matthew Bunce** Executive Director of Finance
09	**Future Direction of Travel**	Opportunity risk of the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.	**Carl James** Director of Strategic Transformation, Planning & Digital,
10	**Governance**	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.	**Lauren Fear** Director of Corporate Governance & Chief of Staff

TAF DEFINITIONS

LEVELS OF ASSURANCE DESCRIPTORS

First Line of Defence functions that own and manage risk	Second Line of Defence functions that oversee or specialise in risk management	Third Line of Defence functions that provide independent assurance
Self-Assurance	**Internal oversight/**specialist control teams, such as**:**	**Internal Audit** (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and **external oversight**, such as:
Risk and control management as part of day-to-day business management	Quality & Safety	External Audit
Staff training and compliance with policy guidance	IT	Regulators & Commissioners
Teams take responsibility for their own risk identification and mitigation	Governance (corporate/Clinical)	Wales Audit Office reviews
		Stakeholder reviews
		Scrutiny from public, Parliament, and the media
Examples of assurance	***Examples of assurance***	***Examples of assurance***
Management Controls / Internal Control Measures	*Board, Committee and Management Structures which receive evidence from the 1st Line of Defence that risks are being*	*Recent internal audit reviews and levels of assurance*
Local management information / departmental management reporting	*Finance reports*	*External Audit coverage*
Divisional / Departmental performance reviews, mandates, outcomes frameworks, objectives (Clinical and Nonclinical services)	*KPI's and management information*	*Inspection reports / external assessment e.g. HIW / NHS Wales other regulator and Commissioner compliance reviews*
Operational planning / Business Plans - Delivery Plans and Action Plans	*Quality, Safety and Risk reports*	*Patient Feedback / Patient experience feedback*
Governance statements / self-certification	*Training records and statistics*	*Staff surveys / feedback*
Local procedures	*Performance reports*	*Comparative data, statistics, benchmarking*
Exceptions reporting	*BAF, VUNHS risk register*	
Targets, Standards and KPIs	*Policies and Procedures including Risk Management Policy*	
Incident Reporting		
Staff Training Programmes	*Compliance against Policies*	

TAF DEFINITIONS

KEY CONTROLS		
CONTROL TYPE	**DESCRIPTION**	**EXAMPLES**
Preventative	These controls are designed to limit the possibility of an undesirable outcome being realised. The more important it is to stop an undesirable outcome then the more important it is to implement appropriate preventative controls.	• Authorisation limits of and separation of duties • Pre-employment screening of potential staff
Mitigating	These controls are designed to limit the scope for loss and reduce any undesirable outcomes that have been realised. They may also provide a route of recourse to achieve some recovery against loss or damage.	• Passwords or other access controls • Staff rotation and regular change of supervisors • Exposure reduction by installation on hours worked
Detective	Control is designed to locate problems after they have occurred. Once problems have been detected, management can take steps to mitigate the risk that they will occur again in the future, usually by altering the underlying process.	• Periodic performance reporting • Regular review

STRATEGIC GOALS	
1	Outstanding for quality, safety and experience
2	An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
3	A beacon for research, development and innovation in our stated areas of priority
4	An established 'University' Trust which provides highly valued knowledge and learning for all
5	A sustainable organisation that plays it part in creating a better future for people across the globe

RISK DESCRIPTORS	
Inherent Risk	Score the exposure before any action has been taken to manage it or if existing controls failed entirely
Residual risk	The threat that remains after all existing controls have been applied
Target risk	Where risks are outside acceptable levels, a target risk score is agreed. This is the level that future mitigation that should be achieved which will vary over time

TAF DEFINITIONS

DEFINITIONS

CONTROL EFFECTIVENESS

Effective	Control in implemented/ embedded; working as designed; with associated sources of assurance	E
Partially Effective	Some aspects of control to be implemented/ embedded; some aspects therefore not yet operating as designed; and may be gaps in associated sources of assurance	PE
Not yet Effective	Significant aspects of control be implemented/ embedded; significant aspects therefore not yet operating as designed; and gaps in associated sources of assurance	NE

ASSURANCE RATING

Positive assurance	the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity	PA
Inconclusive assurance	the assuring committee has not received sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy	IA
Negative assurance	the assuring committee has received reliable evidence that the current risk treatment strategy is not appropriate to the nature and / or scale of the threat or opportunity	NA

TAF DEFINITIONS

RISK SCORE

IMPACT MATRIX

	Impact, Consequence score (severity levels) and examples				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a number of patients	Major injury leading to long-term incapacity /disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which on a large number of patients
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/enquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complain (stage 2) complaint Local resolution (with potential to go to independent Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/competence	Short term low staffing level that temporilly reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for manadtory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours	Local media coverage	Local media coverage	National media	National media

TAF DEFINITIONS

	Potential for public concern	short-term reduction in public confidence Elements of public expectation not being met	long-term reduction in public confidence	coverage with <3 days service well below reasonable public expectation	coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business Objectives/ Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5-10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance Including Claims	Small loss risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5-1.0 percent of budget Claim(s) between £100,000 and £1million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage loss of contract/payment made by results claim(s) >£1million
Service/ business interruptionenvironmental impactr	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on enrionment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

TAF DEFINITIONS

LIKELIHOOD MATRIX

LIKELIHOOD (*)					
LIKELIHOOD SCORE	**1**	**2**	**3**	**4**	**5**
DESCRIPTOR	**RARE**	**UNLIKELY**	**POSSIBLE**	**PROBABLE**	**EXPECTED**
Frequency: How often might it/does it happen	Nopt exepcted to occur for 10 years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occure at least weekly	Expected to occur at least daily
Probability: Will it happen or not?	Less than 0.1% chance	01.-1% chance	1-10% chance	10-50% chance	Greater than 50% chance

RISK RATING MATRIX - IMPACT X LIKELIHOOD

RISK MATRIX	LIKELIHOOD(*)				
CONSEQUENCE(**)	**1- Rare**	**2- Unlikely**	**3 - Possible**	**4 - Probable**	**5 - Expected**
1 -Neglible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 -Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25

TAF DASHBOARD

01 DEMAND AND CAPACITY

RISK ID:	TAF 01	Failure to adequately model demand and capacity and service plan effectively, results in failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control.
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	Jan-22	Goal 2
EXECUTIVE LEAD	Cath O'Brien	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	5	20	3	4	12	3	3	9

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	GOING FORWARD THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Business Intelligance Strategy and delivery plan	Cath O'Brien	X		X	NE	Divisional management review of demand and capacity via Senior Team meetings	IA	Comissioning meetings	P		
C1a	Business intelligence Plan which is based on the Velindre Cancer Service	Lisa Miller	X		X	PE	Divisional Performance Review and the Quality & Perfomance Report review by COO and EMB	IA	Internal Audit	IA		

TAF DASHBOARD

01 DEMAND AND CAPACITY

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1b	Trust Business intelligence plan which is based on the Welsh Blood Service	Alan Prosser	X		X	PE	Donor and patient feedback	P				
C2	Active work ongoing to establish data sets and pathways for the Cancer Service with health boards supported by the Delivery Support Unit.	Cath O'Brien	X			PE						
C3	Structure and function of Business Intelligence and the interface with operational planning, finance and the comissioning arrangements.	Cath O'Brien	X			PE						
C4	Active engagement with Health Boards in Service Planning including the established Service Level Agreement Arrangements in place to plan demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Alan Prosser	X			PE						
C5	Active operational engagement with health boards on demand	Paul Wilkins	X			PE						

GAP IN CONTROLS	GAPS IN ASSURANCE
Business Intelligence strategy and resource plan to be finalised together with implementation plans to build on the existing Business Intelligence functions, capacity and capability that are in place.	More comprehensive overview and traingulation of demand and capacity model shared with Executive Team through divisional review
Wider Business Intelligence alignment with Health Boards	
Further work to improve data insight and use of dashboards in operations	

TAF DASHBOARD

01 DEMAND AND CAPACITY

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE			
Action Plan	**Owner**	**Progress Update**	**Due Date**
1.1 Finalise Business Intelligence strategy	Cath O'Brien	Drafts in progress	TBC
1.2 Structure and function review in Business Intelligence	Cath O'Brien	Further resource identified and review commencing Jan 22	TBC
1.3 Explore participation in national Business Intelligence developments	Cath O'Brien	Awaiting update from Welsh Government	TBC

TAF DASHBOARD

02 PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

RISK ID:	TAF 02	**PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT:** Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	Jan-22	Goal 2
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	3	4	12	2	4	8

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	GOING FORWARD THIS WILL INCLUDE A TREND GRAPH
	PE		

GAP IN CONTROLS							GAPS IN ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1.1	System structures – core cancer services commissioning arrangements.		X			PE	Commissioning contracting reporting	IA				
C1.2	effectively delivering ways of working/ work programmes.			X		PE	Supply and demand reporting	IA				
C1.3	Data and measures to clearly track progress against objectives.				X	PE	Linked through performance framework insight	IA				
C1.4	Blood - core blood services commissioning arrangements.			X		PE	Commissioning contracting reporting	IA			Regulatory scope re MHRA tbc	
C1.5	Effectively delivering ways of working/ work programmes.			X		PE	Supply and demand reporting	IA				

TAF DASHBOARD

02 PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

GAP IN CONTROLS							GAPS IN ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1.6	Data and measures to clearly track progress against objectives.				X	PE	Linked through performance framework insight	IA				
C1.7	South Wales Collaborative Cancer Leadership Group system model.		X			PE	Agreed to model for next phase	IA				
C1.8	Effectively delivering ways of working/ work programmes.			X		PE	Collectively agreed to and documented work programme	IA				
C1.9	Data and measures to clearly track progress against objectives.				X	NE	With respective measures reported	IA				
C1.10	Partnership Board arrangements with partner Health Boards model.		X			PE	Agreed to model for each organisation	IA				
C1.11	Effectively delivering ways of working/ work programmes			X		NE	Collectively agreed to and documented work programme	NA				
C1.12	Data and measures to clearly track progress against objectives.				x	NE	With respective measures reported	NA				

GAP IN CONTROLS	GAPS IN ASSURANCE
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further development required on the ways of working/work programmes and even further development required on the reporting mechanisms	First line of defence assurance are in place to a certain extent across most of the key controls. However, there is limited coverage from second and third line perspectives

TAF DASHBOARD

02 PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE				
Action Plan		**Owner**	**Progress Update**	**Due Date**
1.1	Although each of these mechanisms and controls are reported through various mechanisms – a specific action plan against these controls will be developed and reported through governance to support this strategic risk	Carl James		Dec-21
1.2	Consideration of second and third line opportunities for further assurance to be incorporated into action plan as per action 1.1	Carl James		Dec-21

TAF DASHBOARD

03 WORKFORCE PLANNING

RISK ID:	TAF 03	**WORKFORCE PLANNING:** Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	Jan-22	Goal 2
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
3	3	9	3	3	9	2	3	6

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	GOING FORWARD THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Draft Trust People Strategy clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			PE	Tracking key outcomes and benefits map – aligned to Trust People Strategy		Internal Audit Reports		To be completed as per compliance/ reg tracker update	
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			PE	Staff Feedback		Trust Board reporting against Trust People Strategy		To be completed as per compliance/ reg tracker update	
C3	Workforce Planning – Skills Development – Training and Development Package in Place	Susan Thomas	X			PE	Performance reports via divisional and committee					
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE						

TAF DASHBOARD

03 WORKFORCE PLANNING

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE						
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE						
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE						
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE						
C9	Agile Workforce Programme established to assess implications for planning a workforce followinf COVID and learning lessons will inlcude technology impact accessments.	Sarah Morley			X	PE						

GAP IN CONTROLS	GAPS IN ASSURANCE
Gaps are evident in understanding agreed service models – both internally and regionally	Development of 3rd Line of defence assurance to be completed
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls

TAF DASHBOARD

03 WORKFORCE PLANNING

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE				
	Action Plan	**Owner**	**Progress Update**	**Due Date**
1.1	Paper to Strategic Development Committee with further detail on the plans to develop each of the key controls to an “effective” level	Sarah Morley		Dec-21
1.2	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker	Sarah Morley		Dec-21

TAF DASHBOARD

04 ORGANISATIONAL CULTURE

RISK ID:	TAF 04	**ORGANISATIONAL CULTURE:** The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	Jan-22	**Goal 1**
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
3	3	**9**	3	3	**9**	2	2	**4**

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**GOING FORWARD THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) to be agreed to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			PE	Working group led by CJ		Trust Board reporting on strategy and controls via cycle of business		To be completed as per compliance/ reg tracker update	
C2	Developing Capacity of the Organisation – set out in the Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			PE	Education and training Steering Group		Trust Board reporting on strategy and controls via cycle of business		To be completed as per compliance/ reg tracker update	

TAF DASHBOARD

04 ORGANISATIONAL CULTURE

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C3	Management and Leadership development in place to provide a infrastructure to develop compassionate leadership and managers established via the creation of the Inspire Programme with development from foundations stages in management to Board development	Susan Thomas	X			PE	Education and training Steering Group					
C4	Values to be reviewed and Behaviour framework to be considered Values of the Organisation used in induction, recruitment and via PADR processes	Susan Thomas	X			PE	Healthy and Engaged Steering Group Education and Training Steering Group					
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE	Healthy and Engaged Steering Group					
C6	Health and Wellbeing of the Organisation to be managed –with a clear plan to support the physical and psychological wellbeing of staff	Susan Thomas	X			PE	Health & Wellbeing Steering Group					
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Executive Management Board					

TAF DASHBOARD

04 ORGANISATIONAL CULTURE

C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Working Group					
C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE	SLT Meetings					
C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE	SLT Meetings Edcucation and Training Steering Group					
C11	Development and implementation of a Management Framework that supports cohesive work across the organisation	Carl James	X			PE	To be determined					

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Development of 3rd Line of defense assurance to be completed
Requires a cohesive and holistic Organisation alignment between performance management, service improvement, leadership behaviours and people practices to deliver the desired culture	Mapping of relevant sources of assurance and development of that assurance will sit alongside the development of the key controls

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Paper to Strategic Development Committee with further detail on the plans to develop each of the key controls to an "effective" level	Sarah Morley		Jan-22
1.2	Development of 3rd Line of defense assurance to be completed in line with the development of the compliance and regulatory tracker	Sarah Morley		Jan-22

TAF DASHBOARD **05 ORGANISATIONAL CHANGE 'STRATEGIC EXECUTION RISK'**

RISK ID:	TAF 05	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.								
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal: (See definitions tab)**								
NEXT REVIEW	Jan-22									
EXECUTIVE LEAD	Carl James	**RISK SCORE (See definitions tab)**								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
				0			0			0

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	GOING FORWARD THIS WILL INCLUDE A TREND GRAPH

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**

Timescales for completion TBC

TAF DASHBOARD **05 ORGANISATIONAL CHANGE 'STRATEGIC EXECUTION RISK'**

Timescale for completion TBC

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date

TAF DASHBOARD

06 QUALITY AND SAFETY

RISK ID:	TAF 06	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust traingulated datasets and to systematically demostrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.		
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal: (See definitions tab)**		
NEXT REVIEW	Jan-22	Goal 1		
EXECUTIVE LEAD	Nicola Willams			

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
5	5	**25**	3	5	**15**	2	5	**10**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**GOING FORWARD THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
C1	Once for Wales Datix System implemented	Nicola Williams			X	PE
C2	CIVICA patient/donor feedback system system being implemented	Nicola Williams			X	PE
C3	Trust wide Divisional to Board level Quality & Safety meeting structure in place	EXECS	X	X	X	PE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Staff feedback		Internal Audit Reviews		Audit Wales Reviews	
Patient/Donor Feedback		Quality, Safety & Performance Committee		Health Inspectorate Wales Inspections	
15 Step challenge		Peer reviews		Medicines and Healthcare products Regulatory Agency	
EMB				Professional bodies	

TAF DASHBOARD

06 QUALITY AND SAFETY

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C4	Quality & Safety Teams in place corporately & in each Division	NW, AP, PW	X	X	X	NE	Divisional Q&S Groups PMF				Delivery Unit	
C5	Performance Management Framework (PMF) in place & under review to include experience & outcomes	Carl James			X	NE	Perfct Ward audits PMF					
C6	Trust Risk Register in place	Lauren Fear	X	X	X	NE	Mortality reviews					
C7	Regular Staff Feedback sought	Sarah Morley			X	PE						
C8	Staff Q&S training & Education	Nicola Williams	X			NE	Staff surveys/ feedback		Internal Audit Reviews			

GAP IN CONTROLS	GAPS IN ASSURANCE
National standards / best practice standards (including benchmarkable outcome & experience measures) are not explicit across all departments of the Trust & /or regularly reviewed	Currently mechanisms to automatically & systematically review and triangulate & integrate quality & safety information at corporate and VCC Divisional level are insufficiently robust due to lack of cohesive infrastructure
Data / information infrastructure currently insufficient and unable to provide triangulation	Currently the mechanisms to evidence learning and improvement service level to Board remains under development
Quality & Safety Framework not finalised due to pandemic	There are gaps in the Quality & Safety reporting mechanisms from service level to Board in respect of meeting structures and reporting lines
National Duty of Quality & Candor guidance still under development	Trust Quality, Safety & Performance Committee needs to further refine its work plan, quality of papers and triangulation methodologies
Work required to ensure consistent and recognised Floor to Board lines accountability & responsibility for Quality & Safety	The Trusts performance framework does not currently adequately monitor service level to board quality, safety, outcome and experiential measures
Work required to ensure robust links between incidents, feedback, complaints, mortality review outcomes clinical audit and improvement plans and to be able to demonstrate improvement	Quality & Safety assurance infrastructure for hosted organisations is unclear
Trust wide and VCC Quality & Safety Teams have insufficient capacity and capability to currently be able to fully execute responsibilities	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Trust Quality & Safety Framework to be finalised and implementation plan developed.	Nicola Williams	Trust wide consultation on the Quality & Safety Framework completed. Executive engagement session held. Final version being drafted.	Dec-21
1.2	Corporate & Divisional Quality Hubs to be established	Nicola Williams Paul Wilkins Alan Prosser	Constitution of Corporate Quality & Safety Hub agreed & resourcing determined- awaiting confirmation of funding – aligned with restructuring of corporate Quality & Safety Team. WBS Quality Hub requirements determined – minor changes required from existing arrangements VCC Quality Hub high level requirements determined - additional / realignment of resources maybe required. Detail needs to be worked through	Mar-22
1.3	Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team Divisional Directors	Will be developed once Framework finalised	
1.4	Instigate a Quality & Safety monthly operational meeting where cross cutting outcome review & triangulation takes place	Nicola Williams		Apr-22
1.5	Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	Nicola Williams	Training planned for January 2022	Mar-22
1.6	Implement a robust compassionate leadership programme	Sarah Morley		
1.7	Ensure all responsible officers receive Investigation Training	Nicola Williams Cath O'Brien		Jun-22
1.8	Implement National Duty of Candour guidelines / requirements	Jacinta Abraham Nicola Williams	Awaiting National statutory Guidance. Nicola Williams Chairing national Duty Quality / Duty Candour Steering group	Apr-23
1.9	Implement National Duty of Quality guidelines / requirements	Nicola Williams	Awaiting National statutory Guidance. Nicola Williams Chairing national Duty Quality / Duty Candour Steering group	Apr-23
1.10	Explicitly define the required Quality, Safety & Governance assurance mechanisms for Hosted Organisations	Lauren Fear		Jan-22

1.11	Complete Risk Register Review, transfer onto Datix v14 (04W when available) & ensure regular reviews at all levels in line with Quality and Safety outcomes	Lauren Fear		Mar-22

TAF DASHBOARD

07 DIGITAL TRANSFORMATION

RISK ID:	TAF 07	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of existing and new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.								
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal: (See definitions tab)**								
NEXT REVIEW	Jan-22	**Goal 2**								
EXECUTIVE LEAD	Carl James	**RISK SCORE (See definitions tab)**								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
		3	4	**12**	3	4	**12**	2	3	**6**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**GOING FORWARD THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Digital Strategy	Carl James	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy		SIRO Reports		To be completed as per compliance/ reg tracker update	
C2	Active work on-going to leverage existing and deliver on new technologies – e.g. LIMs, IRS, Becs	Stuart Morris		X		E	Trust digital governance reporting		Internal Audit Reports			
C3	Training & Education packages to develop internal capabilities – including for exec and Board	Stuart Morris	X			PE	Staff feedback		Trust Board reporting against Trust Digital Strategy			

TAF DASHBOARD

07 DIGITAL TRANSFORMATION

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C4	Training & Education packages for donors, patients	Stuart Morris	X			PE	Patient and donor feedback		Feedback and progress of working with Universities			
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Carl James	X			PE						
C6	Specifically development of digital resources capacity and capability	Stuart Morris	X			PE						
C7	Digital inclusion – in wider community	Stuart Morris	X			PE						
C8	Opportunities for digital career paths	Stuart Morris	X			PE						
C9	Prioritisation and change framework to manage service requests	Stuart Morris	X			PE						
C10	Levels of unsupported applications/ legacy systems	Stuart Morris			X	PE						
C11	Trust digital governance	Carl James		X		PE						
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Stuart Morris			X	PE						

TAF DASHBOARD

07 DIGITAL TRANSFORMATION

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls (with exception of c2) requires further development and progression, the plans for which are at varying levels of maturity – see action 1.1	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker see action 1.2
	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls, as per action 1.1

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Chief Digital Officer to bring a paper to next Strategic Development Committee with further detail on the plans to develop each of the key controls to an “effective” level	Stuart Morris		December Strategic Development Committee
1.2	December Strategic Development Committee	Stuart Morris		December Strategic Development Committee

TAF DASHBOARD

08 TRUST FINANCIAL INVESTMENT RISK

RISK ID:	TAF 08	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical & scientific practices and thus ensure appropriate funding mechanisms are in place and agreed.
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal:** **(See definitions tab)**
NEXT REVIEW	Jan-22	**Goal 5**
EXECUTIVE LEAD	Matthew Bunce	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
3	4	**12**	4	4	**16**	3	3	**9**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	GOING FORWARD THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS / SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Financial Strategy	David Osborne	X			PE	Tracking forecast delivery against financial strategy via Performance Committees and Trust Board	PA	Monthly Performance Review with Executives	PA	Monthly Performance Reporting to Senior Management Teams	PA
C2	Active engagement with Commissioners and Welsh Government to ensure inclusion of Velindre requirements within their Financial Planning	Matthew Bunce		X		PE	Inclusion in Health Board IMTP Financial Plans	IA	Monthly Commissioner Meetings held to confirm financial planning requirements	IA		

TAF DASHBOARD

08 TRUST FINANCIAL INVESTMENT RISK

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C3	Active engagement with Trust & Divisions to ensure investment does not exceed available funding	David Osborne	X			PE	Monthly Financial Performance Review Reported to Execs and Senior Management Teams	PA	Quarterly Directorate financial reviews established across both Divisions	PA		
C4	Continuous review of contracting currencies and direct WHSCC funding to ensure reflective of efficient cost of delivery	Matthew Bunce		X		PE	Frequent formal Reviews to be established, combined with routine contract reporting	IA				
C5	Benchmarking with appropriate services to ensure value	Matthew Bunce			X	PE						
C6	Routine contracting reporting and discussion with Commissioners to review activity and early identify income volatilities	David Osborne			X	PE	Monthly Financial Performance Review Reported to Commissioners with Monthly Meetings	PA				
C7	Establish Investment Prioritisation Framework at a Trust and Divisional level to ensure no investment creep and strategic priority alignment	Matthew Bunce	X			PE						

TAF DASHBOARD

08 TRUST FINANCIAL INVESTMENT RISK

GAP IN CONTROLS	GAPS IN ASSURANCE
C3 – Governance of investment at Velindre Cancer Centre is being enhanced through the embedding of resource authorization, prioritization and allocation process, linked to Velindre Futures. Framework not fully embedded at present.	Inclusion of Velindre funding requirements with respective Commissioner financial planning requires formal clarification from Commissioners. Whilst requirements may be acknowledged, the financial challenges that Commissioners are prioritizing may not align with Velindre intents, consequently, assurance cannot be given that Velindre requirements will be met.
C4 – Whilst the contracting model has been continuously reviewed, the impact of COVID related measures has had a potential significant shift in cost base. This requires further understanding to identify mitigations.	The impact of COVID on current performance and cost base remains volatile, with recurrent funding also unclear. Capacity and demand modelling being undertaken in key risk areas. Welsh Government and Commissioners engaged on current and future consequences.
C7 – Trust Investment Prioritisation Framework to be established.	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Support the embedding of investment framework within Velindre Cancer Centre	David Osborne	Process continues to be embedded, terms of reference and process established. Communications throughout Division and “live” operation to follow.	Nov-21
1.2	Review of contracting model for impact of COVID related measures	David Osborne	Areas of concern identified, discussions to inform are underway with Services. Board to be advised of present volatility and Commissioners engaged.	Oct-21
1.3	Establish Trust Investment Prioritisation Framework	Matthew Bunce	Initial proposals prepared, Executive discussions to shape and take forward	Dec-21

TAF DASHBOARD

09 FUTURE DIRECTION OF TRAVEL

RISK ID:	TAF 09	Risk that the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal:** **(See definitions tab)**
NEXT REVIEW	Jan-22	**Goal 2**
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
4	4	**16**	3	4	**12**	2	4	**8**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	GOING FORWARD THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
C1	Development of a Trust strategy and other related strategies (Research Development & Innovation; Digital etc) which articulate strategic areas of priority					PE
C2	Trust Clinical and Scientific Strategy	Nicola Williams	X			PE
C3	Development of a Clinical and Scientific Board to lead clinical direction of travel					PE
C4	Development of improved local, regional and national clinical commissioning arrangements					PE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Tracking key outcomes and benefits map – aligned to Trust Digital Strategy					
Tracking key outcomes and benefits map – aligned to Trust Digital Strategy					

TAF DASHBOARD

09 FUTURE DIRECTION OF TRAVEL

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C5	Agreement of system leadership roles for primary services: 1. Blood Services 2. Cancer Services					PE						
C6	Change in strategic workforce plan to recognise/address any new leadership/clinical/management skills related to strategic growth					PE						
C7	Refresh of Investment and Funding Strategy					PE						
C8	Development of commercial strategy					PE						
C9	Attraction of additional commercial and business skills					PE						

GAP IN CONTROLS	GAPS IN ASSURANCE
To be finalised - please refer to action identified in readiness below	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Develop full suite of strategic documents to provide clarity om future	Carl James		
1.2	Board decision on strategic areas of focus/to pursue	Board		
1.3	Discussion with partner(s) to determine whether opportunity viable	Execs		
1.4	Identify capability required and funding solution/source	Execs		

TAF DASHBOARD

10 GOVERNANCE

RISK ID:	TAF 10	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.
LAST REVIEW	Nov-21	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	Jan-22	**Goal 1**
EXECUTIVE LEAD	Lauren Fear	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
4	4	**16**	3	4	**12**	2	4	**8**

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**GOING FORWARD THIS WILL INCLUDE A TREND GRAPH**
	E		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Annual Assessment of Board Effectiveness	Emma Stephens			X	E	Annual Board Effectiveness Survey Annual Self- Assessment against the Corporate Governance in Central Governance Departments: **Code of Good Practice 2017**	PA	Audit Committee Trust Board	PA	Internal Audit Reports Audit Wales Structured Assessment Programme / Reports Joint Escalation & Intervention Arrangements	PA
C2	Board Committee Effectiveness Arrangements	Lauren Fear	X			E	Internal Annual Review	PA	Audit Committee Trust Board	PA	Internal Audit of Board Committee Effectiveness Audit Wales Structured Audit Wales Review of Quality Governance Arrangements	

TAF DASHBOARD 10 GOVERNANCE

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C3	Health & Care Standards Self-Assessment Arrangements: Standard 1.0 - Governance, Leadership and Accountability	Lauren Fear			X	E	Divisional Management Arrangements for overseeing effective implementation and monitoring	PA	The Trust has an established framework through which self-assessment are undertaken and action taken to implement improvements and changes required – reported on a quarterly basis to EMB Run, Quality, Safety & Performance Committee and Board as required	PA	Annual Internal Audit Report against the Health & Care Standards for Wales (20/21 assessment provided substantial assurance) Audit Wales review outcomes of report as part of Annual Report - Accountability Report	PA
C4	Board Development Programme	Lauren Fear	X			PE	Programme established	IA	Independent member oversighnt via repurposed 'Intergrated Governance Group'	IA		
C5	All-Wales Self-Assessment of Quality Governance Arrangements	Lauren Fear		X		E	Action plan developed in response to self-assessment exercise. All actions complete /on track to complete by end of this financial year.	PA	Monitoring and oversight via EMB and Quality, Safety & Performance Committee	PA	Audit Wales review of Quality Governance Arrangements	PA

GAP IN CONTROLS	GAPS IN ASSURANCE
None	Third line of defense in respect of C4 – Board Development Programme: no course of action is proposed

TAF DASHBOARD 10 GOVERNANCE

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE			
Action Plan	**Owner**	**Progress Update**	**Due Date**
C4 • Development of a more structured needs based approach to inform a longer terms plan for the Board Development Programme.		Supported by the development priorities identified through an externally facilitated programme of Board development underway.	Jan-22
Ongoing input from the Independent Members via the repurposed Integrated Governance Group		Terms of Reference and supporting refreshed standard agenda has been reviewed and is to be agreed by Independent Member by mid December.	Dec-21

TRUST BOARD

TRUST STRATEGY 2022 – 2032

DATE OF MEETING	27/01/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item.

PREPARED BY	Carl James, Director of Strategic Transformation, Planning and Digital
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management	20th December 2021	Approved
Strategic Planning Committee	8th November 2021	ENDORSED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Velindre University NHS Trust has been working to refresh its strategic plans with the aim of setting up a clear strategic direction of travel for the 20220 -2032 period. This includes a Trust mission and vision; goals; and a coherent set of strategies and plans to deliver them.

1.2 The process commenced with a number of Board sessions regarding the mission and vision for the Trust. This was followed by a series of conversations with the wider organization on the mission and vision; a set of strategic goals for 2032; together with discussions regarding the vision for blood and transplantation services; non-surgical tertiary cancer services; and what supporting plans are required to deliver them.

1.3 A series of engagement activities were undertaken to listen to the views of staff, patients, donors and other partners e.g. Community Health Councils. This concluded in October 2021 and allowed a final version of the strategy to be developed.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The draft Trust strategy 2022 – 2032 is attached at Annex 1. It sets out a strategic direction of travel and framework to guide the Trusts' activities over the coming years; taking account of national policy and the operating environment (known and forecast).

2.2 The Trust strategy will be supported by a series of strategies which enable the Trust to achieve its purpose, vision and strategic goals. These include the two frontline service strategic for blood and cancer services; together with the support functions (people, digital, sustainability, innovation and estates). These plans are currently being finalised and will be submitted for consideration by the Trust Board in March 2022.

2.3 It is important to note that if the draft strategy document is approved, further work is planned to provide a high quality presentation of the document (pictographics etc) together with a digital storybook for wider consumption. These will be commissioned once approval is secured.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	It will support the Trust in improving the quality and safety of care
RELATED HEALTHCARE STANDARD	Safe Care
	It will support the Trust in improving achieving the requirements of the Healthcare Standards
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	Will be undertaken before publication in April 2022
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Trust Board is asked to:

i. Approve the Trust Strategy 2022 – 2032.

ii. Receive the further strategic documents in March 2022.

GIG CYMRU NHS WALES
Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

VELINDRE UNIVERSITY NHS TRUST

Destination 2032

(DRAFT)

V.031 18th January 2022: Carl James

Contents

Who we are and what we do…

The Trust was established in 1994 and is one of 11 statutory health organisations in Wales. We are responsible for providing a number of services.

Velindre Cancer Services

Non-surgical tertiary oncology services: we are a specialist treatment, teaching, research and development centre for non-surgical tertiary oncology services to patients from across South-East Wales serving a population of 1.7million

Welsh Blood and transplant Services

A range of essential and highly specialised services including the collection and production of blood and blood components to treat patients; and supporting the transplant programmes through the Welsh transplantation and immunogenetics laboratory services. This is a national service supporting the 3.3million population of Wales

NHS Wales Shared Services Partnership (NWSSP)

We host NWSSP who provide a wide range of support services to NHS Wales including procurement, recruitment and wider back office services

Health Technology Wales

We host HTW which is a national body working to improve the quality of care in Wales. It collaborates with partners across health, social care and the technology sectors to identify, appraise and advising on the adoption of technology or models of care to ensure an all-Wales approach.

We are delighted to present Velindre University strategic plan which sets out:

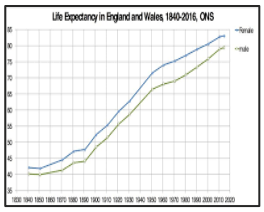
- Why we need a new strategy
- Our purpose and vison
- Our strategic goals for 2032
- How we will work towards 2032. We set out:
    - Our objectives for 2022 - 2027: what we want to achieve
    - how we will achieve it: the key actions we will take
    - how we will know we have got there: the measures

Why do we need a new strategy ?

Across all of our services and the wider health and care system, it is clear that things are changing:

We serve a growing and ageing population, with a range of local challenges relating to health, ill-health and inequalities, requiring us to better coordinate and join up care.

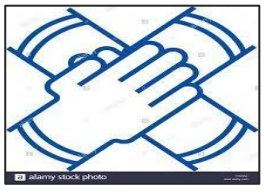
People's expectations are changing with the reasonable expectation that our services will be personalised to their needs. This is challenging us to think differently about how we can modernise and improve the way people access care and the quality and experience of it



There are significant differences in healthy life expectancy and quality of life across different areas within Wales, with recent data suggesting that this gap is widening.

Attracting, training, supporting and retaining the right workforce is one of our biggest challenges and a key challenge across the NHS

Digital technology, innovation and artificial intelligence are creating opportunities to radically transform how we deliver our services and how personalise our services to make them more effective, efficient and valuable to people



We have growing opportunities to collaborate across our regional health system and wider networks to join up care, share learning and improve outcomes.

The climate emergency and need to develop a sustainable approach to living on the planet; a global challenge we need to respond to

Our purpose:

To improve lives

Our vision.....

Excellent care, Inspirational Learning, Healthier people

Our guiding principles: the Well-Being of Future Generations Act (2015).

Everything we do will make a contribution to developing:

A Prosperous Wales

A Resilient Wales

A More Equal Wales

A Heathier Wales

A Wales of Cohesive Communities

A Wales of Vibrant Culture and Welsh Language

A Globally Responsible Wales

How we will work .....

Long-term

Integration

Involvement

Collaboration

Partnership

Our strategic goals

By 2032 we will be recognised as…

1: Outstanding for quality, safety and experience

2: An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations

3: A beacon for research, development and innovation in our stated areas of priority

4: An established 'University' Trust which provides highly valued knowledge and learning for all

5: A sustainable organisation that plays it part in creating a better future for people across the globe

How will we achieve our vision and strategic goals by 2032?

Our objectives are set out below and will guide the delivery of our related strategies and Integrated Medium Term Plans

Strategic Goal 1. Outstanding for quality, safety and experience

Our objectives are to:

- provide harm free care, the best outcomes and a great patient and donor experience
- listen to, and learn from, patients and donors experiences of our care to drive continuous improvement
- be an organisation which consistently demonstrates Compassionate Leadership in everything we do
- be recognised as 'outstanding' by Health Inspectorate Wales, the Medicines and Healthcare products Regulatory Authority and by UK and international peers for the services we provide

We will achieve these by:

- implementing the requirements within the Health and Social Care Quality and Engagement Act
- implementing a quality and safety management framework which will drive every action we take and decision we make
- delivering the national programme for Compassionate Leadership across the organisation.
- continuing the development of a quality led culture which drives the highest standards of care and safety and ensures all staff live the ethos that 'the standard you walk past is the standard we set'.
- getting the basics right by improving access and transport to our services; reducing the need for journeys for care and improving car parking and public transport if you have to visit us
- continuing to develop an open, transparent, just and learning culture which allows excellence to flourish
- Developing a value based healthcare programme which supports us in reducing unwarranted clinical variation and inefficiencies, using best practice as our benchmark.
- providing staff with education, training and support to develop improvement skills and knowledge which drive quality and safety standards
- developing our performance management framework to report our performance on quality, safety and experience in an uncomplicated way which everyone can easily understand and see how we are doing
- benchmarking the quality, safety and experience of our services nationally and internationally to identify learning and improvement

Strategic Goal 2. A leading provider of exceptional clinical services that always meet, and routinely exceed, expectations

Our objectives are to:

- achieve national and internationally recognised standards of care which keep pace with emerging evidence
- be a trusted and influential partner across Wales to deliver great local health services which meet need
- become a 'centre for excellence' and leading provider across the UK for the highly specialist services we deliver
- become a system leader in our areas of expertise, nationally and internationally
- identify a range of new services that the Trust could deliver to improve quality, experience and outcomes across Wales

We will achieve these by:

- applying the National Clinical Framework to the services we provide to improve their quality and the outcomes of them
- implementing our patient/donor/citizen engagement strategy which improves our ability to have conversations with people to understand their needs
- co-designing models of care in partnership with people from all parts of the communities we serve with the aim of providing care at home or close to home wherever appropriate and desired
- delivering services which comply with all statutory legislation and reduce inequalities in healthcare
- rapidly adopting evidence-based research outcomes which improve patient and donors quality, safety and experience of care
- developing and implementing our clinical and scientific strategies which will set out what services we will deliver over the next ten years; focusing our offer on delivering services that we believe we can truly become leading experts in
- agreeing with our Local Health Board partners and the Welsh Government the system leadership roles we will undertake to maximise the value we can add for our patients, donors and partners
- Working with the Welsh Government and other partners to plan, fund and deliver world class buildings, facilities and technology for patients, donors and staff
- benchmarking our performance nationally and internationally to see how we perform against our peers and to identify learning and improvement

Strategic Goal 3: A beacon for research, development and innovation in our priority areas

Our objectives are to:

- deliver world class research, development and innovation to improve tomorrow's care
- accelerate the implementation of research and new discoveries to improve our patient's and donors experience and outcomes
- prioritise research, development and innovation that is clinically relevant, carer, patient and donor centred
- build a sustainable culture of multi-professional research, development and innovation involving the whole organisation
- publish and promote research of the highest quality which achieves UK and international recognition

We will achieve these by:

- giving every donor, patient and carer access to the latest research
- advancing new treatments, interventions and care by increasing new studies locally, widening access to early phase/solid tumour advanced therapies and integrating novel research into clinical studies
- Implementing the Trusts, Welsh Blood Service and Velindre Cancer Centre research and development plans which set out a prioritised programme for research, development.
- building a culture of curiosity where staff challenge the status quo and make it better and research and innovation is an 'Always Event' involving all 1500 employees in the Trust
- increasing the number of lead investigators and clinical academics within the Trust
- recruiting honorary entrepreneurs and academics whilst also developing intrapreneurs, with a flow of staff between our partner organisations on exchanges to attract and retain world class talent
- creating a cadre of blended professionals, to promote knowledge exchange with impact on improvements of patient outcomes
- developing and implementing the Trust's innovation plan in partnership with strategic partners
- establishing exciting work programmes with our local health and academic partners at Cardiff University, Cardiff Metropolitan University, Swansea University, University of South Wales and Trinity St. David's University.
- increasing our research, development and innovation infrastructure to keeps pace with our ambition. This will include:
    - This will include the tripartite research hub with Cardiff and Vale University Health Board and Cardiff University
    - providing world class facilities via the Welsh Blood Service Infrastructure Programme; the new Velindre Cancer Centre; Velindre@ research hubs at University Health Board partners; and the Collaborative Centre for Learning and Innovation
    - developing the Library Service into a sustainable Trust wide Evidence Centre
- Generating reinvestment income through partnerships with industry for commercial research, development and innovation

Strategic Goal 4: An established 'University' Trust which provides highly valued knowledge and learning

Our objectives are to:

- To deliver inspirational teaching which is enhanced and informed by world-class research and professional practice
- Create a supportive and enriching learning environment for all of our learners
- Provide a learning experience that learners rate as excellent
- Be rated as a high quality provider of education and learning nationally and internationally in a number of priority areas
- Raise the profile of the University Trust on a national, UK and international stage.

We will achieve this by:

- developing a highly quality education and training programme which is aligned to the needs of our local, national and international partners
- appointing visiting professors and Professors of Practice to the University Trust, aligning it to key industry and business partners
- attracting academics with national/international reputations and foster partnerships with leading organisations from around the world in our stated areas of priority
- equipping all learners to make the best use of physical and digital learning resources and utilise Cardiff as a living classroom
- increasing our investment in a range of funded strategic initiatives to ensure staff have the time and environment to undertake learning. We will invest additional funds in:
  - supporting our workforce to undertake MSCs and PhDs
  - supporting our workforce to take up Fellowships
  - supporting our workforce to obtain professional, technical and role specific qualifications and accreditations
  - providing research and learning opportunities for students from our university partners, industry and other sectors
- Developing unique learning opportunities in specialist areas including the Velindre School of Oncology and Welsh Blood Service Modernising Scientific careers programme
- developing a marketing and communications strategy which attracts learners to our programmes and raises the profile of the University Trust
- Identifying a range of partners and collaborators to enhance our offer and brand across the globe

Strategic Goal 5: A sustainable healthcare organisation which contributes to a better world for future generation across the globe

Our objectives are to:

- Be recognised as a leading NHS Trust for sustainability locally, regionally and nationally
- Be a carbon 'Net Zero' NHS organisation by 2030.
- Become an anchor organisation in the communities we serve which enhances their economic, social, environmental and cultural well-being
- Support the transformation from ill-health to well-being across Wales

We will achieve this by:

- Developing clinical service models which support sustainability e.g. more care at home and locally Implementing our sustainability strategy
- Applying the principles of the circular economy into our business processes through design, procurement, re-use and lifecycle.
- Developing and implementing a carbon reduction plan which will see us transition to renewable energy for our services and facilities.
- Implementing our plans for waste reduction, reuse and recycling
- Investing in a range of refurbishments and new buildings which will support our carbon reduction and healthier buildings and healthier people approach. These include:
    - major refurbishment and infrastructure upgrade at Welsh Blood Service Head Quarters with Phase 1 in 2022/20203 and Phase 2 in 2024/2025
    - construction of a Radiotherapy Satellite Centre at Neville Hall
    - construction of a new Velindre Cancer Centre by 2024/2025
- Providing a comprehensive education and learning programme which provides staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day')
- Implementing an attractive approach to agile working for our staff which reduces avoidable travel, improves well-being and offers the potential to support money going into local communities
- Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport
- Using our procurement activities and NHS Wales Shared Services capability to drive a sustainable approach and achieve wider ethical and social value in areas including local employment and prosperity; carbon reduction; anti-slavery and unethical practices.
- Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society through employment and apprenticeships, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programmes); becoming an anchor institution in place making; and procurement to maximise the reach of the Trust within the Governments Foundational economy

Aligning our services to achieve our ambitions

Being an employer of choice

Our objectives are to:

- Develop and support a Skilled and Developed Workforce: an employer of choice for staff already employed by us, starting their career in the NHS or looking for a role that will fulfil their professional ambitions and meet their personal aspirations

- Plan and Sustain our Workforce: having the right people with the right values, behaviors, knowledge, skills and confidence to deliver evidence based care and support patient and donor wellbeing

- Grow a Healthy and Engaged Workforce: within a Culture of true inclusivity, fairness and equity across the workforce. A workforce that is reflective of the Welsh population diversity, Welsh language and culture identity.

We will achieve this by:

- Implementing a Health and Wellbeing Framework across the Trust setting out clear and measurable standards to help drive improvement.
- Implementing our education strategy to support staff to grow professionally and offer internal and external pathways to gain experience and knowledge
- Developing our talent management process that supports career pathways so staff have
- Developing our data, information and insight to support the embedding our workforce planning process to support new ways of working for our staff
- Implementing an agile approach to working
- Targeting an increase in bi-lingual recruitment to grow our Welsh speaking workforce
- Improve the way we celebrate success ensuring our staff feel highly valued for the amazing work they do
- Grow the Trust Inspire Leadership and Management Programme
- Working with partnerships both in academia and nationally to ensure the best leadership and management offers are provided for staff including coaching, mentoring and provision of masterclasses

Connecting people digitally to create better care

Our objectives are to:

- Provide resilient digital services which support excellent care
- connect our patients, donors and partners with our workforce in easiest and most effective ways
- become a data driven, insight led organisation where people have the right information at the right time
- secure our data and information through an effective approach to Cyber Security
- create a digital culture of innovation and knowledge sharing that supports the delivery of world class services

We will achieve this by:

- implementing our digital strategy
- constantly evolving our IT infrastructure and security arrangements
- implementing a digital transformation programme to drive benefits and create new forms of value
- developing a digital literacy education programme to support patients, donors, families and our workforce improving their digital literacy
- increasing the speed of development, deployment and functioning of new technologies to increase our productivity
- working with the Centre for Digital Public Services to champion and accelerate digital inclusion
- developing our role within the Digital Intensive Learning Academy
- identifying opportunities to join digital accelerator programmes and initiatives
- revolutionising our business intelligence capability to provide data, information and knowledge to the right person at the right time
- build digital partnerships with partner organisations, academia and digital providers to create value in health, wealth and well-being

Collaboration and partnership: creating more value from our resources

Our objectives are to:

- Join up health and care services by working closely with our health and social care partners to create greater value and benefit
- Act collaboratively to deliver our local, regional and national priorities
- Develop strategic partnerships with organisations to foster innovation, economic growth, health and well-being
- Develop a culture which embeds partnership, collaboration and inclusivity into our organisation DNA.

We will achieve this by:

- Working with our Local Health Boards to improve the commissioning arrangements to ensure services are needs driven and outcome focused
- Developing our role in the Regional Partnership and Public Service Boards around a set of shared goals with our partners
- Expanding our relationship with our volunteer workforce and local community groups to support us in delivering excellent core services and other forms of social value e.g. keeping people active; community cohesion; improving health and well-being
- Developing a culture of collaboration, partnership and innovation through a number of practical steps
  - Providing staff with information, support and 'how to' guides for developing collaboration and partnerships to make success easier to achieve
  - identify innovative ways to fund partnerships and make seed funding available to get things started
  - Develop expertise in commercial / intellectual property areas of business to protect our ideas and maximise the benefits we gain
- Investing more to increase our capacity and capability to develop and manage partnerships with Universities and commercial partners

Providing great places for people to visit and work in

Our objectives are to:

- Provide an estate which enables the delivery of high quality clinical services
- Provide a safe and high quality estate which gives patients, donors, staff and partners a great experience
- Provide healthy buildings which support and enhance individual well-being
- Minimise the impact of our estate on the environment
- Maximise the benefit and social value our estate can provide to our staff, patients, donors and the communities we serve

We will achieve this by:

- Continuously engage with the users of our estate to understand how it can be designed, adapted or enhanced to better meet their needs
- Develop an estate that places human values at the heart of design and embrace opportunities for arts and culture with such spaces
- Investing additional resources in the maintenance of the existing estate to maintain a Category B
- Implementing our estates, digital, workforce and sustainability strategies
- Providing a range of accessible alternative methods of travel focused on walking, bike, public transport and electric vehicles
- Identifying innovative ways to adopt renewable energy sources to service our requirements
- Identifying facilities we can share the use of with other public bodies and wider partners
- Working with the community and partners to identify how we can open up our buildings, facilities and land to be used as communities assets
- Working with partner organisations in arts and culture to seek mutually beneficial opportunities for artistic collaboration across our services
- Delivering a number of transformative capital programmes which have sustainability at their centre of design:-:
    - Refurbishment of the Welsh Blood Service building in Llantrisant by 2023/2024
    - outreach facilities by 2022/2023
    - a radiotherapy satellite centre by 2023/2024
    - the new Velindre Cancer Centre by 2024/2025
    - Refurbishment of the Welsh Blood Service building in Llantrisant.

Investing wisely to create the greatest value

Our objectives are to:

- secure the most value from every £ we invest
- increase our income and available resources to support the improvement of the quality, safety, experience, outcome and sustainability of our services and assets
- use our funding and investments to contribute to the 7 well-being goals set out within the Well-Being of Future Generations Act
- maintain our position as a financially sustainable organisation.

We will achieve this by:

- Developing high quality financial systems which provide us with the intelligence to support prudent investment of our resources to maximise outcomes and social value
- Seek additional capital investment and income to improve services for patients and donors through the adoption of the five ways of working invest for the long term and for the creation of wider value beyond the organisations direct benefit
- Deliver increased and sustainable levels of efficiency and effectiveness through transforming clinical service models and eliminating unwarranted variation
- Developing better commissioning and contracting arrangements with our Local Health Board partners to deliver value from existing, and additional, investment
- Working with partners in 'place making' to secure wider social value from our collective resources in health, social services, education, housing etc.
- Seeking out strategic and commercial partnerships to diversify our income streams
- Securing continued charitable and philanthropic funds to supplement our NHS core funding
- Using the collective scale of the NHS procurement and supply chain to deliver increased value from our funding and support our work in sustainability, poverty, inequality, unethical practices and climate change.

How will we measure our progress?

We will track a range of measures at an organisational level to help us deliver our stated ambitions.

Our care	▪ Access to our services ▪ Never Events per patient/donor attendances ▪ Clinical services: key clinical performance measures and outcomes (benchmarked with our peers) • Ratings by external regulators • Patients and donors that rate their experience as excellent • Staff who say they would be happy for us to provide care and services to a member of their family
Our team	• Diversity of workforce • Staff rate us as an excellent employer • Staff who would recommend us to as an employer to their family or friends
Our learning	• Impact of our research across the world Staff who are routinely involved in research, development and innovation • Staff involved in learning or research • Staff who are lead investigators • Innovation: key markers of innovation (impact and returns)
Our wider contribution to our communities and country	▪ Welsh speakers in the Trust ▪ Carbon emissions ▪ Carbon footprint ▪ Bio-diversity on our sites: value of natural capital ▪ Air quality on sites ▪ Goods and services procured locally within Wales ▪ Sustainable development assessment contribution ▪ Social value: our contribution to society

TRUST BOARD

'VELINDRE @ UHW'
CANCER RESEARCH HUB PROPOSAL

DATE OF MEETING	27th January 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Dr. Mererid Evans, Consultant Oncologist & Associate Medical Director for RD&I / Phil Hodson, Deputy Director of Planning and Performance
PRESENTED BY	Dr. Mererid Evans, Consultant Oncologist & Associate Medical Director for RD&I / Phil Hodson, Deputy Director of Planning and Performance
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, Performance & Estates

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
South East Wales Cancer Collaborative Leadership Group	22nd October 2021	ENDORSED
VUNHST Executive Management Board (Shape)	22nd November 2021	ENDORSED
VUNHST Strategic Development Committee	9th December 2021	ENDORSED

ACRONYMS	
CCLG	South East Wales Cancer Collaborative Leadership Group
FBC	Full Business Case
LHBs	Local Health Boards
NT	Nuffield Trust
VUNHST	Velindre University NHS Trust

1. SITUATION / BACKGROUND

1.1 The purpose of this paper is to provide the VUNHST Trust Board with a draft proposal ***(Annex 1)*** to develop a tripartite Cardiff Cancer Research Hub at the University Hospital of Wales (UHW), Cardiff.

1.2 The draft proposal is a tripartite partnership between Cardiff and Vale University Health Board (CAVUHB), Cardiff University (CU) and Velindre University NHS Trust (VUNHST). This will further develop the research and development (R&D) infrastructure in Wales further through the establishment of a joint Cancer Research Hub to make Cardiff, and indeed Wales, competitive on the UK cancer research stage.

1.3 In September 2020, VUNHST appointed the independent health think tank, the Nuffield Trust, to provide advice on the clinical model within the Transforming Cancer Services Programme. The purpose was to provide independent expert advice to the Trust on the regionally integrated, networked clinical model for non-surgical tertiary cancer services across South East Wales, which included consideration of the implications for cancer research.

1.4 The Cancer Research Hub ambition is aligned with the Nuffield Trust recommendations to VUNHST and its University Health Board (UHB) partners which included, a recommendation to develop a ***'strong research hub at UHW to bring together patients, NHS researchers (from CVUHB and VUNHST) and academic researchers (from CU School of Medicine) in one location'***.

1.5 A letter from the Deputy Chief Executive, NHS Wales, to the Chief Executives and Medical Directors of all SE Wales Health Boards and Velindre University NHS Trust in April 2021, also reiterated the requirement to develop ***'a hub at the University Hospital of Wales for patients receiving complex and early phase experimental or advanced therapies'*.**

1.6 The proposed tripartite hub will provide focus and facilities for cancer research in Cardiff and offer opportunities for closer working with the University ***(Note: the proposal is summarised in Annex 2)***.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 A tremendous amount of collaborative work and engagement has been undertaken between the tripartite partners leading to a strong consensus regarding the future direction of travel for the draft Cardiff Cancer Research Hub proposal.

2.2 Although the proposal is very well developed, it will remain in draft whilst further detailed operational details are developed and an investment and funding strategy agreed. The final proposal will then be submitted for approval through appropriate governance arrangements.

2.3 Once the final proposal receives the appropriate clinical and governance approvals, the team will look to implement phase one of the proposal during 2022-2023.

2.4 In addition, there will be a need to submit a business case(s) for elements of the service that require significant revenue or capital investment to deliver the new Cardiff Cancer Research Hub.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes – revenue investment will be required but no commitments will be made prior to commissioner / Trust Board approval

4. RECOMMENDATION

4.1 The VUNHST Board is asked to:

- **ENDORSE** the draft proposal to establish a tripartite Cardiff Cancer Research Hub at the University Hospital of Wales (UHW), Cardiff ***(Annex 1)***
- **NOTE** the next steps / actions as summarised below:
    - To seek endorsement of the draft proposal from both Cardiff and Vale University Health Board and from Cardiff University
    - To establish a Velindre@UHW Research and Development Project Board (1st meeting – 24th January 2022)
    - To develop a phased implementation plan for phase 1 of the Project
    - To develop a robust investment and funding strategy, supported and agreed by all partners.

Cardiff Cancer Research Hub

Proposal for a Tripartite partnership between Cardiff and Vale UHB, Cardiff University and Velindre University NHS Trust

August 2021

Contents

Document control

Joint proposal	Cardiff and Vale UHB, Cardiff University and Velindre university NHS Trust
Archus file ref.	https://archusuk.sharepoint.com/sites/Southwest/Shared Documents/Clients/Velindre/Joint proposal Cardiff Cancer Centre/Joint Proposal_Cardiff Cancer Centre draft v8.docx
Prepared by	Produced on behalf of the two Trusts by Archus Ltd
Date	January 2022
Checked by	R,D&I Management Lead
Date	January 2022

1 Executive Summary

This proposal is an iterative document. This version reflects the situation as of August 2021 and is prepared in accordance with the guidance given in developing a joint proposal for the Cardiff Cancer Research Hub – a Tripartite partnership for integrated working in cancer research and education between Cardiff and Vale UHB, Cardiff University and Velindre University NHS Trust.

The proposal is to support an agreed phasing of joint working in ensuring that the Trust's and University are aligned to the current and emerging service need, is safe, of a high quality and providing value for money to the Trust.

This proposal has been produced from an evaluation of existing work and ambition for the future, guidance from key national and regional bodies and an extensive stakeholder engagement programme to understand current challenges and future service strategies for research and education, which have been translated into an agreed 'phasing' approach to meet the overall strategic priorities which the proposals align to.

The proposal assesses:

- Where the services are now and what are the current successes.
- Where do the services want to be within the Tripartite partnership.
- How to get there using phased approaches that best meets patients and service needs.

2 Purpose of the proposal

2.1 Background and objectives

Health Boards, Velindre University NHS Trust and partners have an exciting vision for world class cancer services which deliver high quality care and clinical outcomes for the population of South-East Wales. In support of this, the Cancer Collaborative Leadership Group is providing strategic leadership and co-ordination to realise the vision at both a regional and local level. Within this, there are a number of major service and infrastructure developments planned in delivery which will assist in accelerating the delivery of enhanced patient benefits.

Within Cardiff, these include the development of cancer treatments and technology. These will be supported by the planned development of UHW2 and the new Velindre Cancer Centre which had Welsh Government approval for the outline business case (OBC) in April 2021. Consequently, a once-in-a lifetime opportunity exists for the region to develop world class services and infrastructure which are sustainable for decades to come. These include world class cancer services, genomics, immunotherapy, precision medicine and research, development and innovation. This will create 'network' effects with generation of strategic and commercial partnerships and support the broader Welsh Government policy aims e.g. economic prosperity; safe and cohesive communities and deliver high quality, efficient and effective integrated cancer pathways. This will ensure access to care that meets the needs of the local and regional population in a safe and sustainable way.

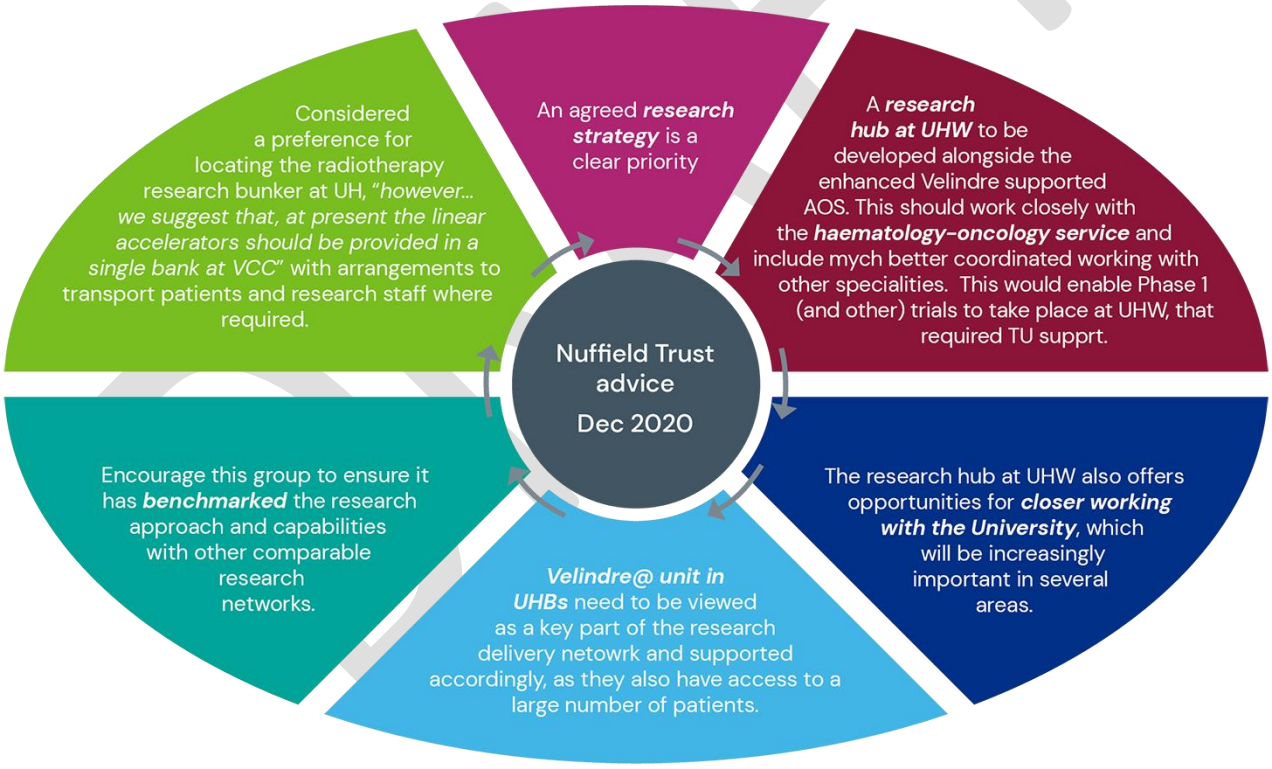
A number of required actions by the Trust and its partners (specified in letter from Simon Dean, Deputy Chief Executive of NHSW), included the establishment of the research hub at UHW for patients requiring complex systemic treatments as well as closer working with haemato-oncology services which would be enabled by the hub and regional research network. Partnership Boards have since been convened between CVUHB, VCC and CU and a key focus of these Boards is the establishment of the tripartite hub, associated work-programmes and workforce models for delivery.

Research and Education across Cardiff and the Vale UHB, Cardiff University and Velindre University NHS Trust work have been working in partnership to deliver cancer services for South Wales populations and the current services are of a high quality with partnerships between the organisations felt to be strong.

The patient pathways between the organisations for research opportunities are not fully developed and are not yet fully integrated across the system for a number of reasons; allowing for much opportunity for further strengthening services through integrated pathways that will give patients much improved access to research-based treatments whilst allowing services to develop enhanced and new treatments in a safe way through high quality joined up pathways for admissions.

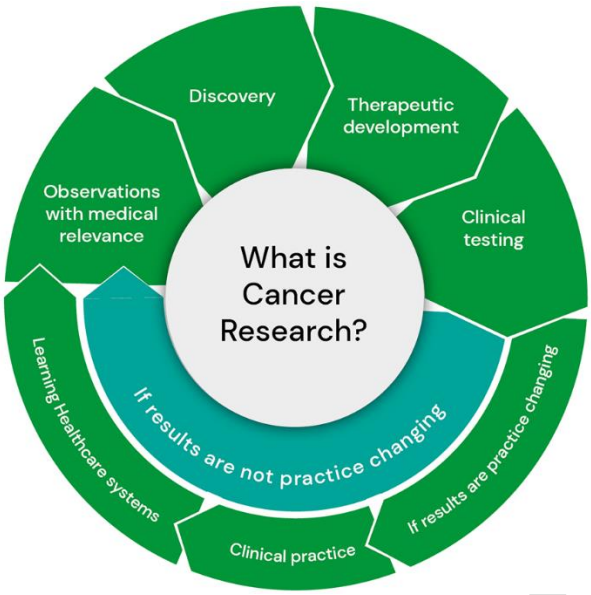
These discussions are supported by the Nuffield Trust report which was received on 1st December 2020 that set out recommendations for consideration by the regional partners. The ones specific to this proposal are:

- Recommendation 4: The new model should not admit patients who are at risk of major escalation to inpatient beds in VCC. These patients should be sent to district general hospital sites if admission is required, to avoid a later transfer. The admission criteria for inpatient admission to VCC therefore needs to be revised to reduce the risks associated with acutely ill patients. Regular review of admissions and transfers should be used to keep this and the operation of the escalation procedures under review.
- Recommendation 5: To support recommendations 4 and 5, and the research strategy, a focus on cancer including haemato-oncology and a hub for research needs to be established at UHW. There would be advantages to this being under the management of VCC, but in any case, the pathways between specialists need work in order to streamline cross-referral processes. Such a service would provide many of the benefits of co-location – access to interventional radiology, endoscopy, surgical opinion, critical care and so on – albeit without the convenience of complete proximity.



3 Strategic objectives

3.1 Strategic background - Oncology Research and Education



Cancer research is research into cancer to identify causes and develop strategies for prevention, diagnosis, treatment, and cure.

Cancer research ranges from epidemiology, molecular bioscience to the performance of clinical trials to evaluate and compare applications of the various cancer treatments.

These applications include surgery, radiation therapy, chemotherapy, hormone therapy, immunotherapy and combined treatment modalities such as chemo-radiotherapy. Starting in the mid-1990s, the emphasis in clinical cancer research shifted towards therapies derived from biotechnology research, such as cancer immunotherapy and gene therapy.

Cancer research can be divided into several broad categories:

- **Basic research** is the study of animals, cells, molecules, or genes to gain new knowledge about cellular and molecular changes that occur naturally or during the development of a disease. Basic research is also referred to as lab research or preclinical research.
- **Translational research** describes an approach that seeks to accelerate the application of discoveries in the laboratory to clinical practice. This is often referred to as moving advances from bench to bedside.
- **Clinical research** involves the application of treatments and procedures in patients. Clinical researchers conduct clinical trials, study a particular patient or group of patients, including their behaviours, or use materials from humans, such as blood or tissue samples, to learn about disease, how the healthy body works, or how it responds to treatment.
- **Population research** is the study of causes and patterns of occurrence of cancer and evaluation of risk. Population scientists, also known as epidemiologists, study the patterns, causes, and effects of health and diseases in defined groups. Population research is highly collaborative and can span the spectrum from basic to clinical research.

Clinical and translational oncology research is a most important factor in the advancement of treatments for different cancers. According to the National Cancer Institute, clinical research studies are crucial for physicians to find new ways to improve cancer treatments. It is critical to understand the role of clinical research in oncology, as it is central for leading, discovering and improving cancer treatments for people both within Wales and across the world.

Looking at improving net-survival estimates by stage at diagnosis for 1- and 5-years are currently able to be presented following diagnosis for 24 cancer sites. Estimates by stage at diagnosis are not available for brain, non-Hodgkin lymphoma, kidney and urinary tract, pancreas, and leukaemia. This is because of complexities within different subtypes of a cancer site or because staging systems do not exist for all or some subtypes of the cancer.

For the 24 cancer sites with reported survival by stage estimates, there is a known stage for 85.3% of diagnoses. This is an increase 3.2 percentage points higher than in the diagnoses up to 2016 and reflects the increase in developments for diagnosis for each of the 24 cancer sites. As the number of diagnoses with a known stage increase, the survival estimates for each stage captures a more accurate and wider range of patients' survival experiences.

Not only is there much evidence that clinical research within cancer care can provide better treatments, but it can also help researchers better understand the causes and nuances of different cancers. When patients participate in clinical trials, they help add to the knowledge about cancer to improve cancer care for future patients. Clinical trials can help researchers find new ways to prevent and detect cancer, and they can also help improve the quality of life for patients during and after treatment.

One of the main benefits of clinical research is that it can allow cancer patients to gain access to new treatments faster, which could be the difference between life and death for many patients. In many situations, participation in a clinical trial is the standard of care recommended by practice guidelines depending on the patient's stage and response to other therapies. It is known that improving diagnosis in the early stages of cancer offers patients a range of treatments that have a greater chance of being curative than if their cancer is diagnosed at a later stage.

Therefore, oncology clinical research not only has a major impact on future patient outcomes, but it also plays a significant role in the care of patients who are currently fighting cancer.

The integration of cancer research and education across Velindre, Cardiff and Vale and Cardiff University will push forward jointly agreed strategies to maximize innovation for cancer clinical research to continually increase numbers of patients, with physicians from across the country, whilst providing an optimum infrastructure and environment for patients to be provided with the safest and highest quality care.

Further development of research within Cardiff will allow the accumulation of extensive knowledge about the biological processes involved in cancer onset, growth, and spread in the body will allow development of breakthroughs in treatment as a result of research and discoveries made by scientists in a wide array of disciplines over decades and even generations.

The aim of the 'Hub' will enable progressive safe and effective methods to prevent, detect, diagnose, treat, and, ultimately, cure some of the diseases of cancer to transform and saves lives. The better the understanding of these diseases, the more progress services provided for patients across Wales will make toward diminishing the immense human and economic cost of cancer.

3.2 The story so far - achievements to date

The UK Government sets out bold vision for the future of clinical research delivery and Cardiff and Vale and Velindre are research active organisations.

Figure 1 - Future of Clinical Research Delivery

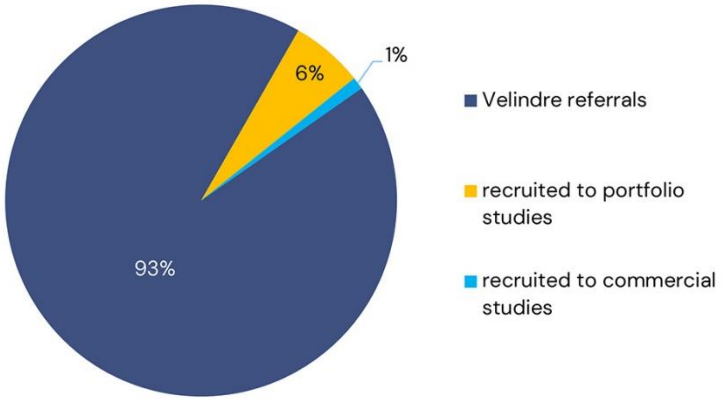
Cardiff has the largest number of cancer Chief Investigators (CIs) in Wales (31/34 CRUK grants in Wales 2013-2019 led by Cardiff CIs).

Southeast Wales has the largest patient recruitment to cancer clinical trials in Wales (149 cancer trials open 2019-20, ~1950 patients recruited).

The 1st solid tumour cancer early phase trials unit in Wales opened at Velindre 2013.

Cardiff and Vale and Velindre have worked closely with Experimental Cancer Medicines Centres (ECMC) to make early phase trials and novel treatments available to patients from across South Wales and a key part of the future is the building of links with Cardiff University for translational research.

Figure 2 - Velindre referral and recruitment figures



There are a number of current challenges and, it is felt, an immediate need for the services to increase more widespread opportunity for cancer patients' access to research and current numbers remain less than desired by the clinical and research teams.

The ambition to change this means the services must:

- Enable early phase trials of 1st in human treatments that require access to HDU/ITU/other specialities.
- Streamline R&D processes (mean time to complete feasibility and confirm capacity and capability 2020-21 150 days.)
- Develop closer partnerships with academia to enable translational and reverse translational research.
- Build critical mass and the research workforce of the future.

3.3 Cancer research and development ambitions

Velindre University NHS Trust (VUNHST), Cardiff and Vale UHB (CVUHB) and Cardiff University (CU) have a shared ambition to work in partnership together and with other partners to develop a **Cardiff Cancer Research Hub**. Cancer research in South-East Wales is considered by clinical and academic teams to be at a crossroads and a joined up tripartite approach and investment is needed, to make it competitive on the UK cancer research stage.

This ambition is aligned with the Nuffield Trust recommendations to VUNHST and its University Health Board (UHB) partners (1 Dec 2020) which included, a recommendation to develop a "**strong research hub at UHW**" to bring together patients, NHS researchers (from CVUHB and VUNHST) and academic researchers (from CU School of Medicine) in one location. This tripartite hub will provide focus and facilities for cancer research in Cardiff including:

This tripartite hub (potentially called a Cardiff Cancer Research Hub) will provide focus and facilities for cancer research in Cardiff including:

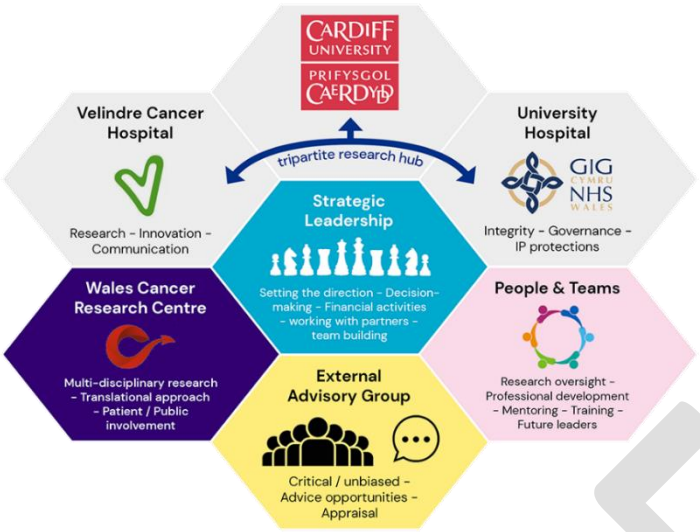
- Delivery of Early Phase Clinical Trials (EPCTs) and Advanced Cellular and non-Cellular Therapies (AT) for solid cancer and haematological malignancies, with access to HDU/ITU and specialist services (e.g. surgery, cardiology, immunology, gastroenterology) to manage the complications of therapy and enabling collaboration between solid cancer and haem oncology research.
- Delivery of complex late phase research trials which require access to specialist services.
- Enabling "closer working with the university", bringing academic and NHS researchers together and creating the translational pipeline required to bring new discoveries from the laboratory to the clinic in Wales.
- Clinic, office and meeting space, with direct links to the laboratory, biobank, surgery, interventional radiology and other specialities.
- An enhanced, integrated, multi-disciplinary Clinical Academic workforce, developing future research and research leaders.
- Education and training, inspiring the next generation of cancer researchers in Wales.
- Space for associated research infrastructure/partners in Cardiff/Wales.

3.3.1 Main Aims

The main aims of a tripartite Cardiff Cancer Research hub will be:

- To **increase patient access to research,** including Early Phase and Advanced Therapies (AT) trials for solid cancer and haematological malignancies
- Enabling scientists to bring new discoveries through to the clinic by **strengthening the translational pipeline**
- Developing a **focus for cancer research** excellence in Wales to enhance the collective reputation and attract future funding, partners and staff.

3.4 Outputs and principal agreements for integrated service design



A cross-site Research and Development Clinical Design Workshop stakeholder was held on the 8th June 2021 and attended by multi-professional teams across VUNHST, CVUHB and Cardiff University to further develop the concept.

The outputs of the workshop recognised that a hub and the associated areas of research have the scope to improve research access for patients in South Wales and beyond, bringing "benefits and success for all" partners, by:

- Providing a supported environment for the delivery of EPCTs including, those utilising Advanced Therapies (ATs)
- Increasing research options for Welsh patients nearer to home
- Delivering research care in a safe and seamless way
- Providing a pipeline of late phase trials and benefits for future cancer patients
- Building research critical mass, expertise and infrastructure
- Better connecting academic researchers and clinical researchers
- Facilitating both research development and delivery (NHS/Academia)
- Increasing the scope and reach for UK research partnerships and collaborations
- Providing opportunities for shared learning, training, education and career pathways to inspire, train and mentor future clinical and non-clinical cancer research leaders
- Delivering high quality and research-led teaching at both undergraduate and postgraduate level, and to inspire others to pursue excellence in research, teaching and innovation. Producing high quality research measured by publications, impact, income, increased CU impact cases and Research Excellence Framework (REF) status
- Improving income generation (commercial trials, industry investments, grant awards etc)
- Enhancing Cardiff/Wales research competitiveness at UK level and how Cardiff/Wales is perceived by key research funders
- Improving research status and reputation for all partners involved.

3.4.1 Agreed clear principles and next steps.

There was a clear consensus on taking forward a phased approach to the development of a cancer research Hub on UHW site. By adopting a phased approach, it was agreed that the immediate need would be addressed for enhanced access to early phase trials and ATs for solid cancer.

This would then allow the development towards a future-proofed tripartite cancer research hub on UHW site. A number of distinct time phases were suggested:

1. The immediate term classified as the first eighteen months (from July 2021 to Jan 2023.) Intermediate term over the following 30 months (Feb 2023 to July 2025 and the long term over years 6-10 (Aug 2025 to Jul 2030.)

In the immediate term, the following areas need to be agreed upon: the Cardiff Cancer Research Hub (location, partnerships and models of working). The first phase will be to run complex and early phase studies in the existing Clinical Research Facility (CRF) at UHW, whilst at the same time develop plans for the Tripartite Cancer Research Hub, suggested to be operational in 18-24 months' time.

This proposal is to support any future development of an emerging business cases for medical and clinical oncology academics to include the ECMC applications to CRUK and the emerging pipeline of AT trials. As part of this, integration for solid tumour and haematological EPCTs could also be developed in the same stepwise manner.

2. There will be a need to work with all partners to agree the detailed plans for the future Cancer Research Hub and the opportunities it offers.

The ambition is clear for the partnership across CVUHB, CU and Velindre and other partners in the development of a Cardiff Cancer Research Hub including the delivery and development of EPTs and ATs (Haem Onc and Solid Tumour) and a harnessed approach (NHS and Academia) for translational research. The scope to improve research access for patients in South Wales and beyond will be described in the proposal demonstrating how it will bring "benefits and success" for all partners.

3. There will be a need for dedicated resources to enable complex and early phase studies to be run at the CVUHB over the next 12-18 months

It was agreed that the written proposal for the workforce will need, over the next 2 years, to demonstrate the need for a flexible and agile research nursing workforce that works together across two locations. The flexibility will be to work to different inductions and SOPs; the current staffing model will need some workforce uplift to be identified.

Agreements for medical capacity, have the opportunity to include Clinical Research Fellows supporting specific research work programmes both in terms of laboratory work as well as patient management within the CRF/Hub and "Out of Hours medical cover". It was felt this could include middle grade staff such as a junior doctor linking in with the acute oncology service (AOS) work programme, haemato-oncology and with study Principal Investigators (PIs.)

Academic medical oncologists/clinical oncologists will provide leadership for EPCTs, ATMPs, drug radiotherapy studies including the Radiotherapy Research Bunker associated with nVCC. the development of translational research (associated with Genomics, Radiation and Immuno-oncology.) This will be delivered with the appropriate workforce to enable the potential increase of solid tumour trials supporting the ambition to double recruitment and expand the research portfolio and will be confirmed in the written proposal.

4. The Tripartite Hub will be for far more than Early Phase trials and will require phasing of infrastructure to support the outputs

The infrastructure for the Tripartite Hub will also be phased to match the immediate need and the intermediate and future plans bringing NHS and academic researchers together to enable translational and reverse translational research. The expanse of the opportunity includes 'Late phase' trial patients who may need biopsies, procedures or monitoring, research allied to Acute Oncology Service and unscheduled care and the creation of a focus for cancer research in Cardiff/Wales to inspire the next generation, education and training.

The clinical facilities from the immediate to the final phase will be described in the proposal. This will not only include the number of beds, couches and chairs; but a description of the research bed requirement in the critical care footprint for highest risk 1st in human cellular therapies, along with Haematology, emergency and patient monitoring equipment access for specialised clinical care, appropriate equipment for PK sampling, and monitoring equipment and access to vaccine treatment room and vaccine investigational medicinal product (IMP) preparation room which will be required in the intermediate stage and also consider the 'hot desk' space and IT facilities for the attending VCC EPT clinician and nurse/s and possible overnight accommodation for an on call clinician.

4 Scope and service overview

The service overview is described following a review of the current pathway of care for patients taking part in research-based activity across Velindre, Cardiff and Vale and the wider parts of Southeast Wales.

4.1 Service scope – current research activity

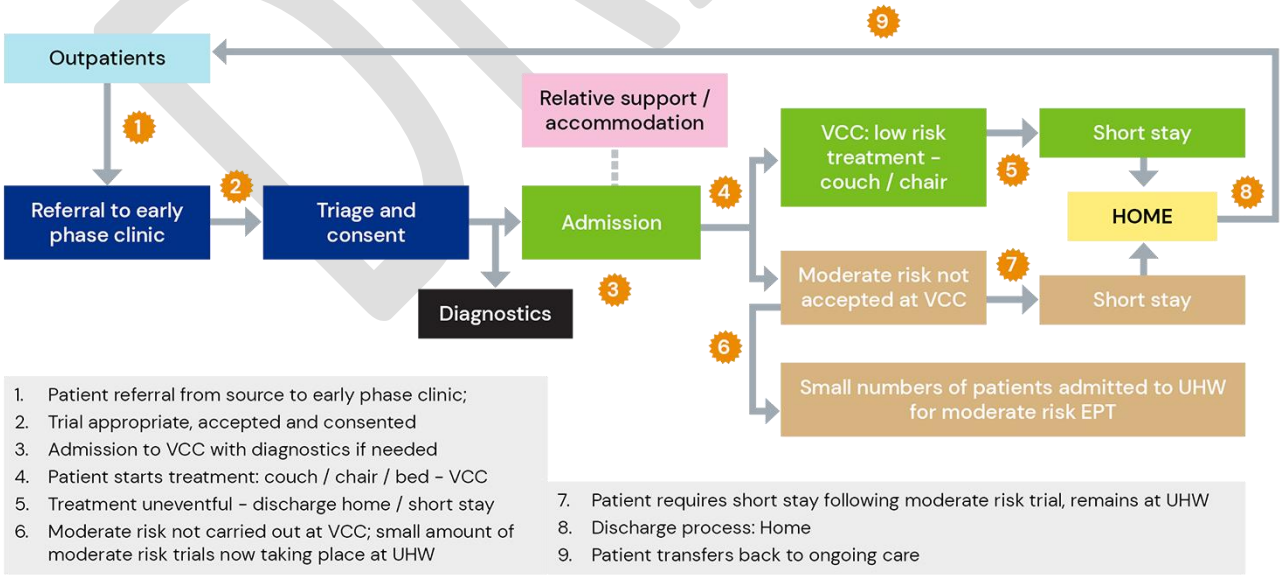
4.1.1 Velindre

Solid cancer EPCTs/ATs

The solid cancer Early Phase Clinical trials (EPCTs) Unit opened at Velindre in 2012, allowing Welsh cancer patients access to Phase 1 trials closer to home (in line with Welsh Government policy), as opposed to travelling to Southampton, Oxford or London. Over the last 6 years Cardiff's Experimental Cancer Medicines Centre (ECMC) and the Wales Cancer Research Centre (WCRC) have provided funding to CVUHB and VUNHST to support EPCTs and ATs. Since opening, the early phase unit in VCC has conducted 40 EPCTs and has developed a track record of delivering such trials. This has improved the cancer research profile of both VCC and Wales, increasing collaboration between research institutions within Wales to deliver translational cancer research projects. Whilst the research facility is based on the Velindre site, there is no suitable area for patients having higher risk research-based treatment due to a need to be able to access high dependency care (Nuffield report – recommendation).

The current patient pathway for research-based treatment and trials, from admission to transfer home is demonstrated below with early phase trials at VCC. The range of treatments delivered are low risk and therefore limited. A small number of moderate risk trials are now managed at UHW.

Figure 3 – Pathway diagram – current



1. Patient referral from source to early phase clinic;
2. Trial appropriate, accepted and consented
3. Admission to VCC with diagnostics if needed
4. Patient starts treatment: couch / chair / bed - VCC
5. Treatment uneventful - discharge home / short stay
6. Moderate risk not carried out at VCC; small amount of moderate risk trials now taking place at UHW
7. Patient requires short stay following moderate risk trial, remains at UHW
8. Discharge process: Home
9. Patient transfers back to ongoing care

There are a total of 30 in-patient beds on the Velindre site – with 10 of these currently out of service due to Covid-19. The Clinical Research Treatment Unit has 4 beds and 6 chairs.

The usual activity from these beds is being managed through day-case work. The day unit has a total of 12 couches/beds for patients receiving treatment on a daytime only basis.

4.1.2 Cardiff and Vale

There have been no dedicated cancer research beds at UHW and patients that are admitted whilst having cancer treatments or trial medications will access the hospital via the emergency department, medical assessment unit or as a direct transfer from VCC, if complications arise or medical support is required.

Over recent months medical and nursing teams from VCC have been integrating services across the two sites and supporting patients with treatments that would not be suitable to be delivered at VCC. This change in practice has given opportunity for the clinical teams to start to look at the wider opportunity for access to more research studies, the type of facilities that will be needed to deliver the clinical care and work with colleagues to look at the practical and governance related aspects of joint services.

The main cause of concern for further expansion of the services in research development is that without dedicated facilities in UHW, some moderate and all high-risk trials will not be able to be undertaken as patients will increasingly require a dedicated area with access to interventional radiology treatment or high dependency care beds.

4.1.3 Research Activity

VCC's EPCT portfolio includes Phase1, Phase I/II and Phase II and includes drug, drug-radiotherapy and combination EPCTs including a mix of commercial and non-commercial studies. These allow VCC to attract grants from external sources such as the ECMC and the WCRC, Third Sector and income generated from commercial monies.

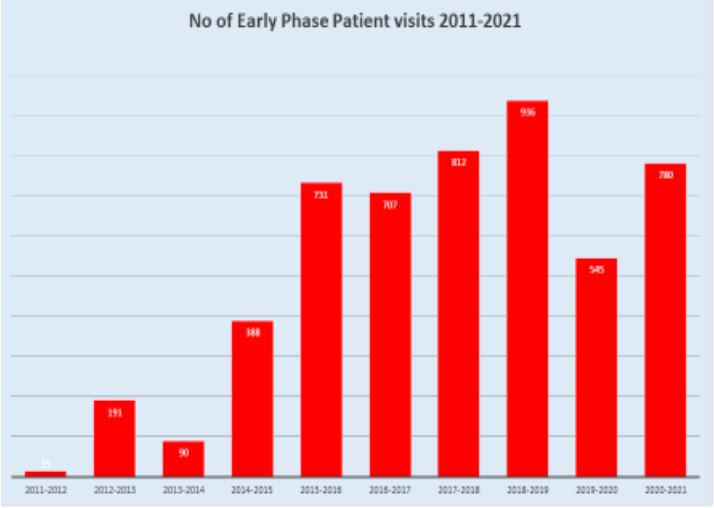
Over the last 5 years, on average each year:

- 5 new EPCTs are opened (includes Phase I Phase I/II and some Phase II.)
- 120 patients are referred for EPCTs from South Wales and beyond, of which, 64 patients are suitable to be seen in clinic for trial and of those 38 patients are consented and screened.
- There are 760 EPCT's patient visits; such visits are associated with screening, consent, delivery of trial treatment and trial related tests and follow up.
- Different EPCTs require different bed/chair hours. As an example, the least intensive EPCT require 3 hours per visit during first cycle of treatment, whilst the most intensive requires 14 hours per visit bed hours during first cycle of treatment. Overall, a complex first in human trial can involve 55-60 patient management hours in the first four weeks of treatment, compared to standard care which requires 2-3 hours.

Building on this success, the aim is to increase future research opportunities for patients, enabling access to **novel, potentially lifesaving or disease modifying therapies, or treatments** they might not otherwise be offered outside the context of a trial.

Enhancing EPCT's capacity in terms of strategy, focus, delivery, partnerships, reputation and opportunities and outcomes for patients will potentially attract significant income.

Figure 4 - Current research activity levels are illustrated in the table showing VCC Early Phase Clincal Trials and number of patient visits



Haemato-oncology EPCTs and ATs

There has been a year-on-year growth in activity in EPCTs for patients with haematological malignancies over the last 5-6 years in terms of the breadth of subtypes of haematological cancers covered by EPCTs, the numbers of open studies and the numbers of patients recruited. The vast majority of these studies are run and administered through the Clinical Research Facility at UHW (CVUHB.) Haemato-oncology studies have also benefitted from CRUK funding (Cardiff ECMC), the WCRC and the well-established Trials Acceleration Programme (TAP) Centre (formerly funded by Bloodwise, now by Cure Leukaemia). The haemato-oncology EPCT portfolio has included a mix of Phase I, Ib and II studies, increasingly featuring first-in-human haematology trials, including studies with Cardiff-based Chief Investigators, linked to Cardiff University-based translational research.

There is an increasing focus of activity on haemato-oncology EPCTs involving 'Advanced Therapies' which will continue to grow as a proportion of total activity. Two phase 1 studies of bi-specific antibodies (T-cell engagers) have recently opened and a further adoptive T-cell study in Acute Myeloid Leukaemia is in set-up. The cellular therapy service within Haematology at CVUHB includes the well-established regional delivery of haematopoietic stem cell transplantation (autologous and allogeneic) and CAR-T therapies and has just opened its first CAR-T trial (phase III); is now well-positioned to expand into early phase cellular therapy studies, including CAR-T. In recent years, there has been growing cross-site collaboration between haematology and solid tumour early phase researchers (ECMC, WCRC) as best exemplified by the TC Biopharma adoptive T-cell study for patients with advanced solid tumours which had joint Principal Investigators (CVUHB and VCC), utilising haematology apheresis services at UHW and early phase units on both sites.

Expected increase in research activity and future challenges

VCC clinical teams report that as from 2012-2019, almost every EPCT could be run at VCC. However, during the last two years, VCC have been approached to take on more complex EPCTs due to the changing landscape of the novel therapies that are being developed, for example: immunotherapy, virotherapies and cellular therapies.

To date, VCC has not yet conducted any ATs (Solid Tumour) trials, however Advanced Therapies Wales Team have identified that from the emerging pipeline of 27 trials (over the next 18 months - 3 years), 45% are oncology trials. There are Haem-oncology ATs being worked up at CVUHB. There is an urgent need to gear up infrastructure and expertise to conduct such trials for solid cancer patients too, allowing Welsh patients to gain access to these therapies, as well as informing future ATs that will become standard practice.

EPCTs complexity is partly due to the type of the interventional trial drug, its delivery method and associated patient reaction/clinical risk. To fully optimise EPCT activity, there is an immediate need to treat patients in an NHS location where there is access to level 2 and 3 facilities for those developing critical illness. To illustrate this, in January 2020 – April 2021, Velindre has submitted Expression of Interest (EOIs) for 35 EPCTs. Of these, 14 EOIs (40%) required patients to be dosed at UHW, allowing access to services such as critical care for safe patient management. It should be noted that even if such support services were in place, not all 14 EOIs would have progressed to EPCTs setup as Cardiff may not have been a selected site by every Sponsor/commercial company.

There is requirement to assess the need for adequate infrastructure and workforce models including medical, nurse and research administrative cover to work across both sites, aligning research delivery with the clinical service. Academic Medical and Clinical Oncologist capacity will be necessary to drive and lead, if solid cancer and haemato-oncology EPCTs and ATs targets are to be realised.

Translational Research: Linking academia and the clinic.

It is envisaged that the Cardiff Cancer Research Hub will enable closer working with the university, promote a better-connected cancer research community, inspire future cancer researchers and research leaders and become a focus for education and training that will grow the next generation of cancer researchers in Wales. The possibility of co-locating cancer research infrastructure and partners (e.g. WCRC, ECMC, Wales Cancer Bank) at the Hub has been supported by teams across sites which aligns with the aims of the WCRC, that identified in its 2020-25 bid that there is a need to address the **translational gap** between ‘discovery’ research and delivery of its benefits to patients in routine clinical cancer services. It also is of critical importance to the success of Cardiff’s ECMC bid in 2022 and is integral to the success of the themes priorities for future research in the future Cancer Research Strategy (CReSt) for Wales. See Section 5.2.2

Specific exclusions

The main exclusions noted for this proposal are Children under 16 years of age.

4.2 Data and demographics

4.2.1 Population figures and trends

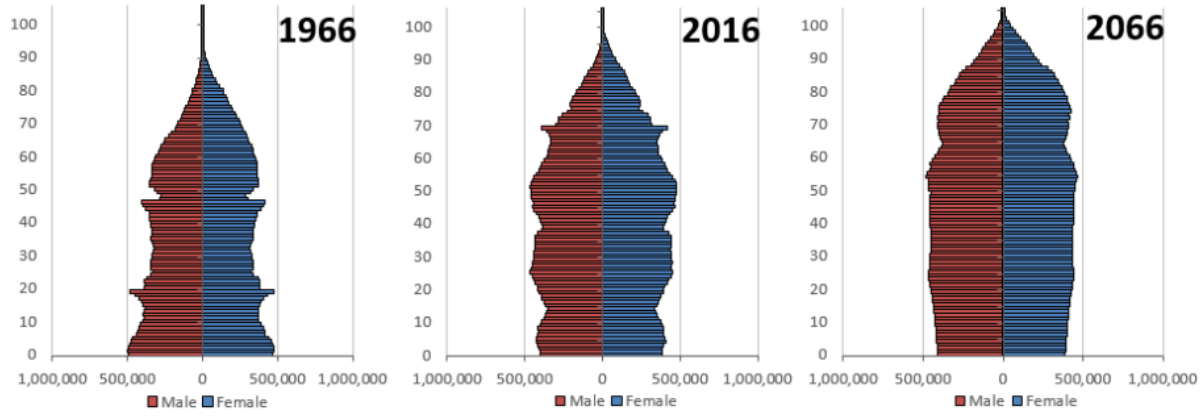
In order to correctly assess cancer services future demand, assessing how the population is changing across Wales is an important fact in evidencing and establishing the numbers of patients with more complex conditions and the likely increases in requirements for cancer services. Specifically in regard to access to research-based treatments in the future so that sensible projections are made that inform the infrastructure for the Research Hub for patients and staff,

including assessing the potential for treatment provision and financial impact of the changes both in income and expenditure terms.

It is well known that population projections have long shown that the UK's overall population is ageing[1]. The population has been steadily getting older and this trend is projected to continue in the future. In 2016, there were 11.8 million residents aged 65 years and over, representing 18% of the total population – 25 years before, there were 9.1 million, accounting for 15.8% of the population.

Looking ahead to 2066, it is estimated there will be a further 8.6 million people aged 65 years and over, taking the total number in this group to 20.4 million and making up 26% of the total population. This increase in numbers is broadly equivalent to the size of the population of London today.

Figure 5 – demographic population projections



The changing and ageing structure of the population is driven primarily by two factors. Firstly, improvements in life expectancy mean that people are living longer and reaching older ages. Along with this, there has been a decrease in fertility, people are having fewer children and are having children later in life.

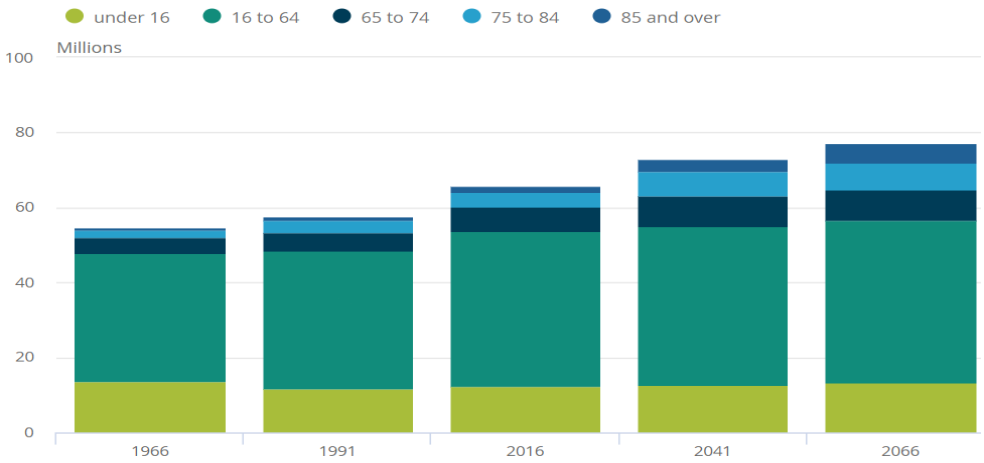
The fastest increase will be seen in the 85 years and over age group.

[1] ONS projections England and Wales 2020

In mid-2016, there were 1.6 million people aged 85 years and over (2% of the total population).

By mid-2041 this is projected to double to 3.2 million (4% of the population) and by 2066 to treble.

Figure 6 - Population by age group



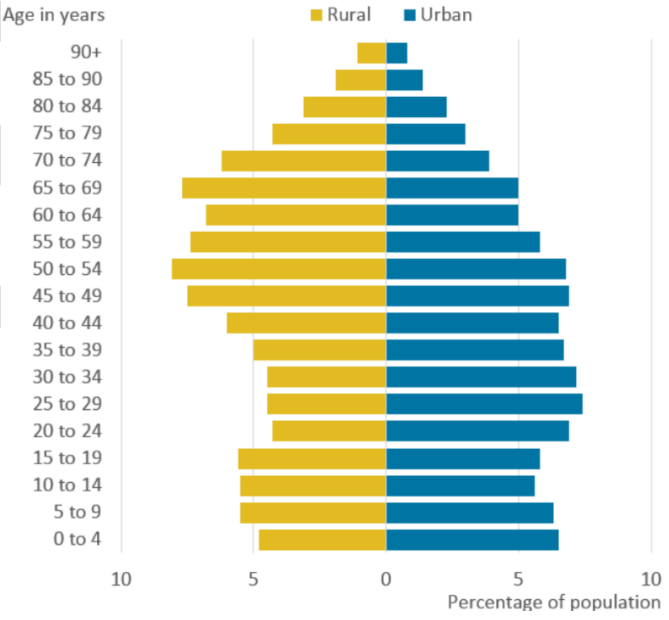
There will be 5.1 million people aged 85 years and over making up 7% of the total population. In contrast, the population aged 16 to 64 years is projected to increase by only 2% over the next 25 years and by 5% by 2066.

For Wales, an important note is that the older populations are not equally spread across local areas, with older people making up higher proportions of the populations within rural and coastal areas than urban areas where more than 21.6% of the population are aged 65 years and over.

Looking ahead, the population aged 65 years and over is projected to grow by around 50% in both urban and rural areas between 2016 and 2039.

In comparison, the younger population (aged under 65 years) is only projected to grow by 8% in urban areas, with virtually no increase in the younger population in rural areas. This will result in an increase in the ratio of older to younger people, particularly in rural areas.

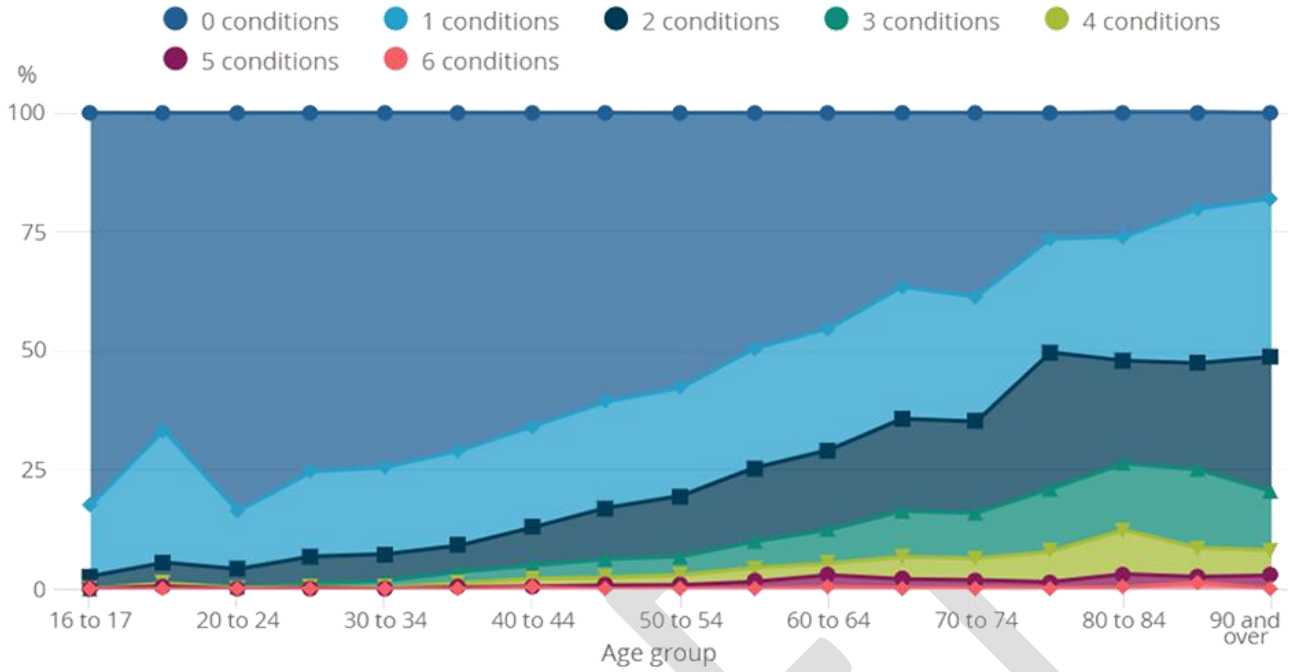
Figure 7 - Percentage of population within age bands by rural-urban classification



4.2.2 Implications for cancer services

Declining mortality rates mean higher life expectancies and with life expectancy projected to continue to increase across Wales, requirements for cancer services and patients able to have equal access to the best therapies and research is of vital importance.

Figure 8 - Growth in service requirements by complex health conditions



Whilst the chart above demonstrates at age 65 years, both men and women can expect to spend around half of their remaining life expectancy in good health, the likelihood of experiencing multiple chronic and complex health conditions does increase with age.

And as, life expectancy increases, the impact on services providing care across different disease profiles is significant and that new therapies as a result of research will be of increasing value to the population as a whole.

Growth assumptions

The assumptions for increased bed, couch and chair requirements are based on the expected expansion to research and education services and have been discussed during the stakeholder engagement forums. These will be further linked to the overall longer-term requirements and are discussed in Section 6.

Initial requirements suggested:

- 4 Early phase trial beds for treatments increasing to 8 beds initially and then to 12 beds
- 6-8 chairs for early and late phase trial patients needing biopsies/investigations/bloods and linking with laboratory research, increasing to 12 chairs.
- Access to 1-2 research beds in the high dependency (critical care footprint) for highest risk 1st in human advanced therapies, along with Haemato-oncology.

5 Proposal and requirements

5.1 Case for change

The overall ambition is to work in partnership with Velindre, CVUHB, CU and other partners in the development of a Cardiff Cancer Research Hub. There are key associated clinical research work programmes suggested within the Hub including the delivery and development of EPCTs and ATs (Haem Onc and Solid Tumour) and a harnessed approach (NHS and Academia) for translational research.

Both the Hub and these areas of research have the scope to address the requirements and improve research access for patients in *South Wales and beyond*, bringing "**benefits and success for all**"

5.1.1 Joined up tri-partite approach

Clinical teams feel that they are at an important stage in their joint ambitions to create a research 'Hub'. To succeed they need a **joined-up tripartite approach** and **investment** to be competitive on the UK cancer research stage. Cardiff's failed RadNet and CRUK Centre bids (2019, 2021 respectively) identified that lack of critical mass, focus and absence of a clear translational pipeline are barriers to funding. Cardiff's ECMC bid in 2022, will need to set out strategic plans and that these previous barriers have been addressed.

Despite the challenges, it is now an unparalleled time to be involved in cancer research, development and innovation at Velindre, Cardiff and Wales. Led by Health and Care Research Wales (HCRW), the **Wales Cancer Research Strategy (CReSt)** is being developed and it is expected to complete and receive sign-off in the next few months. It will recognise that building on existing research strengths in Wales and building closer links between the NHS and academia to enable the translational pathway from discovery science to the clinic, are fundamentally important developments for Cardiff and Wales.

There is also governmental and organisational commitment to developing the Hub. Furthermore, Welsh Government's approval for the outline business case (OBC) for the new Velindre Cancer Centre in April 2021 was contingent on a number of required actions by the Trust and its partners (specified in letter from Simon Dean, Deputy Chief Executive of NHSW) – these included the establishment of the research hub at UHW for patients requiring complex systemic treatments as well as closer working with haemato-oncology services which will be enabled by the Hub and regional research network.

Partnership Boards have been convened between CVUHB, VCC and CU and a key focus of these Boards is the establishment of the Tripartite Hub, associated work-programmes and workforce models for delivery.

5.1.2 Other Partners

ECMC Cardiff funding from CRUK and Welsh Government (WG) funding ceases March 2023. ECMC Cardiff has begun to work up an application in readiness for the CRUK competitive open call in 2022. Given the financial climate, this will be extremely competitive process across the UK. To support such an application, it will be essential to present a joined-up approach for EPCTs across institutions and partners.

The **Wales Cancer Research Centre** (funded by HCRW from 2020 until 2023 with a potential extension until 2025) is set to address the **translational gap** between 'discovery' research and delivery of its benefits to patients in routine clinical cancer services. Furthermore, it has a EPCTs and ATs work programme (haematological and solid cancer); outcomes from this work-plan are likely to be reviewed by Health and Care Research Wales (HCRW) in the next 18 months.

Research interactions with the Wales Cancer Bank (WCB), CRUK CTR (Cancer), Marie Cure Palliative and Supportive Care Research Centre, CU's Schools of Medicine, Biosciences and the Engineering as well as the Systems Immunity Research Institute will be essential. The opportunity to co-locate a number of these Cardiff-based Welsh cancer research infrastructures in the Hub needs to be explored.

Advanced Therapy Wales (funded by Welsh Government) and ATTC Midland/ Wales (funded by Cell and Gene Catapult): in the last 2 years WG issued a Statement of Intent for AT and funds Advanced Therapies Wales programme team that supports the delivery of this intent. In addition, ATTC Midland/Wales (working up its Phase 2 application for a further 5 years funding) and the ATW programme team has identified a pipeline of 27 global trials coming through over next 18mths - 3 years; 45% of these are oncology trials and the Cardiff Cancer Research Hub will enable delivery that would otherwise not be possible in Wales.

5.1.3 Leadership and models of working

Enabling increased EPCT solid tumour, AT activity and translational research will require a critical need for additional clinical academics in both medical and clinical oncology.

To address this, Velindre and the Division of Cancer and Genetics (CU) are developing joint business cases to uplift the clinical academic capacity to a further 2 WTE initially, with a clear plan to develop further critical mass within the clinical academic workforce over the next 5-10yrs. Such posts will be vital to the development of the cancer research hub, and will require some individuals to be capable of delivering complex Solid Tumour First in Human and other Advanced Therapy trials, as the teamwork in partnership (VUNHST, CVUHB and CU.) In addition, scoping the uplift of research nurse and research support staff capacity will be needed and is described in the workforce section below.

Over the last three years, VCC and the Clinical Research Facility have worked in collaboration with C&V Haematology in successfully delivering Wales' first ever adoptive T-cell therapy study. Currently both EPT's teams are collaborating to set up 2 trials, providing opportunities for learning that will inform best operational working going forwards, as well as setting foundations in terms of working relationships, contractual arrangements, governance, trial setup, communications, shared workforce models and related financial reimbursements etc. A key part of this is that the increased work for the trials cannot be carried out without some investment in posts (medical nursing and research administrative posts) to allow new and different work across different sites.

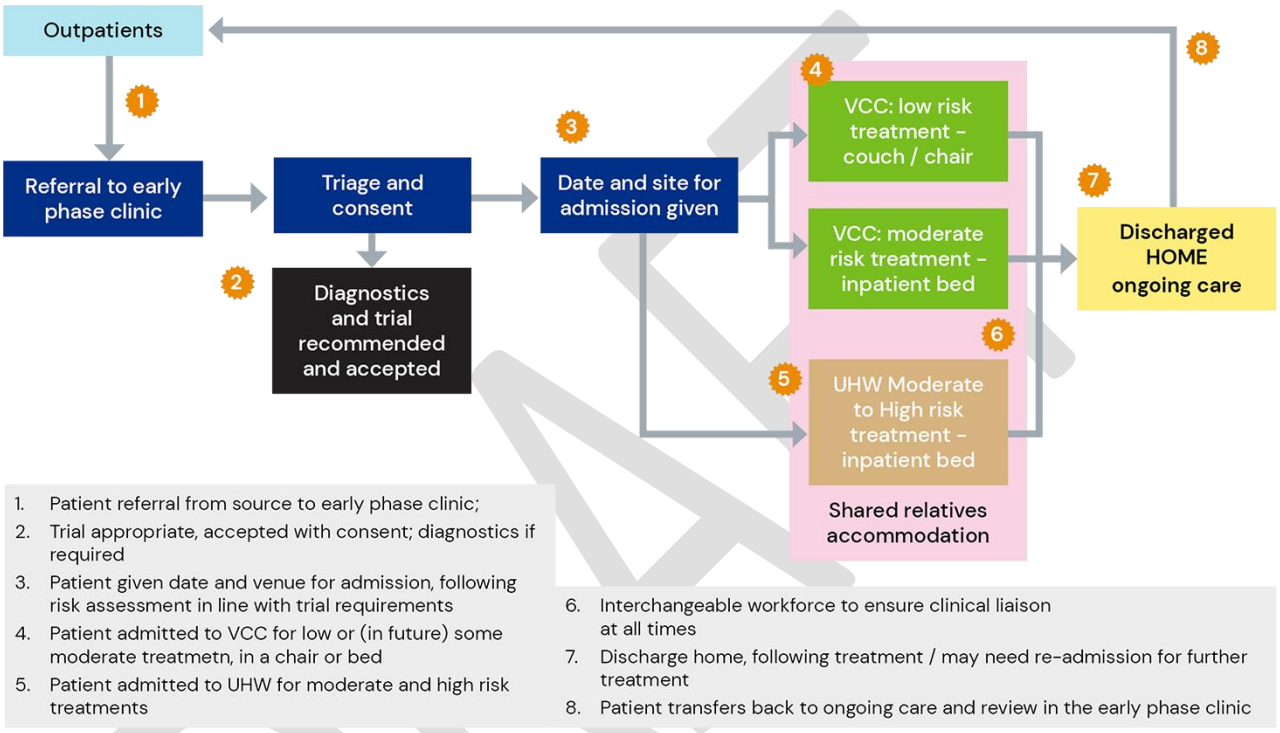
In future however, not all VCC's EPCT portfolio will need to be delivered on the UHW site. Indeed, not all EPCT protocol driven care will need to be delivered at UHW. There is a likelihood that VCC EPCTs and ATs location for delivery of investigational (drug/vaccine /immunotherapy etc.) will be decided by the *risk* associated with the type of trial intervention, its delivery mechanism and risk of side effects/ risk of patient reactions with trial procedures and patient visits moving seamlessly between the two sites in a shared working model.

The future joined up pathway changes the way that research services will be delivered.

As EPCTS and ATs are set up each trial will be assessed for risk and the best location for the delivery of the trial drug will be determined.

Once the patient has consented, has undergone trial screening and met trial eligibility criteria, they will be given a date and time for admission at the appropriate site for trial drug delivery to commence. This will be part of a phased implementation process as the range of treatments and trials grows and admission pathways and bed numbers increase. The changes for patients within the pathway are demonstrated below:

Figure 9 – Pathway diagram– future



5.2 Proposal

5.2.1 Early Phase Trials (EPCTs) and Advanced Therapies (ATs)

For EPCTs it was noted at the Clinical Design workshop that the aims should be to provide enhanced access to patients with both solid tumours and haematological cancers by:

- Exploring opportunities to work collaboratively between solid cancer and haemato-oncology, driving plans to deliver EPCTs across Velindre and UHW sites as per the Nuffield recommendations.
- Advancing collaborations with Cardiff University scientists, ECMC and the WCRC to deliver bench to bedside projects with Cardiff generated molecules/therapies.
- Designing and delivering Investigator-led EPCTs with Welsh Chief Investigators through interaction with Industry, Academic colleagues, Cancer Research UK (CRUK), Cancer Research Wales (CRW) and other funders.

- Developing a broad, well-balanced EPCT portfolio including both commercial and academic investigator-led studies, aiming to double patient recruitment to EPTs in South Wales within 10 years.
- Expanding the portfolio of solid cancer novel Drug-Radiotherapy Combination studies.
- Expanding EPCTs activity in advanced therapies for both haematological and solid tumour indications (multiple modalities including CAR-T therapies, vaccine therapies, virotherapies and T-cell engaging antibody therapies.)
- Taking patient referrals from across South Wales and beyond.

For solid cancer **Advanced Therapies** (ATs), the aims will be to provide enhanced access to patients by:

- Seeking opportunities to lead with partners at CVUHB the delivery of clinical trials to test the benefit of ATs in solid cancers (involving gene therapy, vaccine therapies, cell and tissue-based therapies and tissue engineered products) for the population of South Wales.
- Learning from the experience and expertise of haemato-oncology colleagues of delivering ATs (e.g. CAR-T therapy) for haematological malignancies and supporting closer working and co-localisation to expedite necessary knowledge transfer and delivery capability.
- Investing in the infrastructure and workforce required to deliver these therapies.
- Joining a collaborative network of R&D delivery teams across the UK to share experience and best practice in this emerging field of research.
- Pro-actively seeking out and developing links with academic and commercial developers to partner within ATs clinical translation and trial delivery.
- Utilising the knowledge gained in delivering ATs in a trial setting to facilitate and expedite their adoption and equitable availability as routine standard of care when fully licenced and commissioned.

Notably, within **two years** – to open at least one solid tumour non-cellular advanced therapy trial (for example an oncolytic virus) and one cellular advanced therapy trial annually. Within **five years** – to open two solid tumour non-cellular and cellular advanced therapy trials annually. Within **ten years** to open **five solid tumour non-cellular and up to 5 cellular advanced therapy trials annually**.

5.2.2 Translational Research – Linking academia and the clinic

The 2021 Cardiff CRUK Centre bid (led by Professor Awen Gallimore, CU's Cancer Theme Lead) focused on the discovery and development of novel immuno-therapeutics, specifically the development of novel T-cell based therapies. Feedback from CRUK highlighted that the bid was unsuccessful for two main reasons:

1. The "hand-off" between pre-clinical and clinical work packages (the 'translational pipeline') was not clear in Cardiff.
2. The bid was "too narrow" highlighting lack of a critical mass of cancer researchers in Cardiff with CRUK programmatic funding.

Despite these issues, the EOI was positively received by CRUK who recognized future opportunities in **advanced T cell therapies** in Cardiff. They also highlighted (in verbal feedback) future opportunities in **cancer vaccines** (building on the UK's success with COVID-19 vaccines.)

It is imperative to address the pre-clinical to clinical interface and build critical mass in Cardiff to attract future infrastructural funding from CRUK and other funders, including industry. The Cardiff Cancer Research hub provides us with this opportunity, bringing NHS, academic and clinical academic ('interface' post holders) together to ensure that new discoveries made in Cardiff/Wales are translated through to the clinic for patient benefit.

For translational research it was noted at the Clinical Design workshop that that the aims were to:

- Strengthen the "hand-off" between pre-clinical and clinical research in Cardiff enabling our scientists to bring new discoveries through to the clinic (the 'translational pipeline') to benefit Welsh patients.
- Enable reverse translation – using patient samples to inform new discoveries.
- Focus on opportunities to develop novel immuno-therapeutics including advanced T-cell based therapies in Cardiff and the future potential for cancer vaccines.
- Build critical mass in Cardiff to attract future infrastructural funding from Cancer Research UK (CRUK) and other funders.
- Bring NHS, academic and clinical academic researchers together in the hub to promote collaboration and develop a sustainable workforce.

It is envisaged that the Cardiff Cancer Research Hub will enable closer working with the university, promote a better-connected cancer research community, inspire future cancer researchers and research leaders and become a focus for education and training that will grow the next generation of cancer researchers in Wales. The possibility of co-locating cancer research infrastructure and partners (e.g. WCRC, ECMC, Wales Cancer Bank [WCB]) at the Hub was supported at the workshop.

This aligns with the aims of the WCRC which is funded by HCRW from 2020 until 2023 with a potential extension until 2025) and aims to address the **translational gap** between 'discovery' research and delivery of its benefits to patients in routine clinical cancer services. It also is of critical importance to the success of Cardiff's ECMC bid in 2022 and is integral to the success of the themes priorities for future research in the future Cancer Research Strategy (CReSt) for Wales.

5.2.3 Proposal for implementation

Two principals have been proposed by clinical and operational teams:

1. Dividing studies according to 'risk'
2. Promoting a phased approach to implementation

Dividing studies according to 'risk'

Future studies (for solid cancer and haem-oncology) should be divided according to 'risk':

- **Low risk EPTs** will continue to be delivered and managed in Velindre Cancer Centre (and/or by the Haematology Clinical Research Group for haem-oncology studies).

- **Intermediate risk EPCTs and ATs** require investigational drug delivery and supportive care and will need to be delivered on UHW site supported by VCC staff (with screening, consent and follow-up managed by VCC team in VCC).
- **High risk EPCTs and ATs** require the investigational drug and specialised supportive care to be delivered in the critical care footprint on UHW site (being led by Dr M P Wise, R&D Director, (CVUHB). This is anticipated to start in next 1-2 months for a haemato-oncology 1st in man bispecific monoclonal antibody being tested. VCC research nurses will support here (with screening, consent and follow up managed by VCC team in VCC).

5.3 Phased implementation

Given the emerging discussions around the Cardiff Cancer Research Hub, development of emerging business cases for medical and clinical oncology academics, the ECMC applications to CRUK, and the emerging pipeline of AT trials, it is suggested that development of the hub and its activities should be developed in a stepwise manner.

By adopting a phased approach, the partnership can address the immediate need (enhanced access to EPCTs and ATs for solid cancer) whilst building towards a future-proofed tripartite cancer research hub on UHW site.

Distinct time phases are suggested:

Term	Stage	Date
Immediate Term	First 18 months	July 2021 to Jan 2023
Intermediate Term	Following 30 months	Feb 2023 to Jul 2025
Long term	Years 6-10	Aug 2025 to Jul 2030

In the **immediate term** the proposal is to use the existing **Clinical Research Facility (CRF)** on UHW site for intermediate risk studies which cannot be delivered at VCC. Also to:

- Utilise the High Consequence Infectious Diseases (HCID) unit at UHW as appropriate for high risk EPCTs which require trial interventions that include vaccinations
- Use a refurbished critical care footprint for high-risk early phase & Advanced Therapy studies (solid cancer & haem-oncology [happening in the next 4-8 weeks for haemato-oncology study]).
- Complete a review of the nursing/medical model for clinical cover [clinical research fellows/honorary contracts] and investment in the delivery workforce

For high-risk Haem-Oncology trials, the appropriate location will be determined on a trial-by-trial basis. In addition to the locations listed above, other locations such as the Bone Marrow Transplant Unit may be utilised.

In the **intermediate and longer term**, the aim is to develop:

- A Clinical Research Facility (CRF) **in the clinical area** (covering Haematological and solid cancers) known as the Cardiff Cancer Research Hub or **(the "Hub"),** to deliver 'intermediate risk' Early Phase studies, provide a focal point and facility for translational research with

university partners, enable late phase studies for Cardiff patients and allow opportunities for education and training. The Hub should be located close to the Acute Oncology Service so that research and clinical care can be delivered seamlessly.

- A Clinical Research Facility (CRF) **in the critical care area** – for 1st in human solid cancer and haemato-oncology early phase and advanced therapies. Research and critical care will be delivered seamlessly in this unit.

These will provide a unique selling point for Cardiff and Wales, attracting commercial income, enhancing research reputation and attracting and retaining high calibre staff.

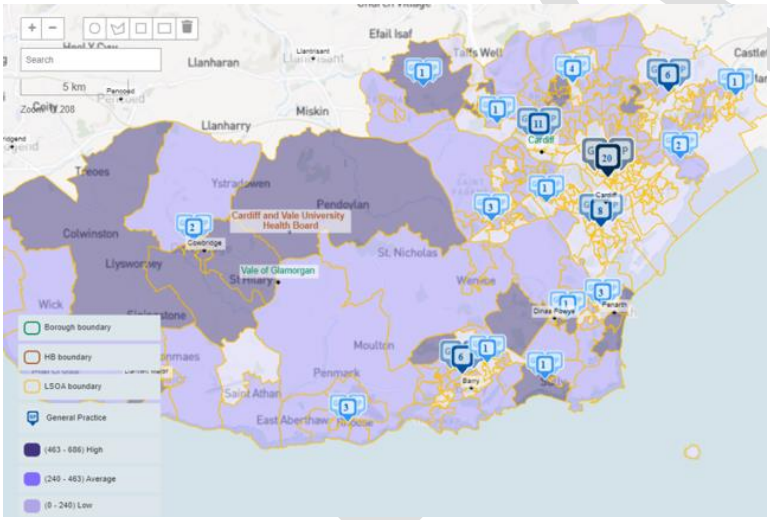
In summary, the workshop agreed clear principles and consensus on a model for the future Cardiff Cancer Research Hub and work is now required to develop a detailed implementation plan and seek investment for it on a tripartite basis.

For details of operational actions to be undertaken for the immediate term see **Appendix 2.**

5.4 Referral and access

5.4.1 Geographical coverage / boundaries

The main geographical coverage will be within Cardiff and Vale Health Board, which will be expected to increase in numbers based on the aging population and particularly where more dense areas of the older populations reside. However, as the research activity grows so will the coverage across South-East Wales.



Referrals for research-based treatments will be made by the attending Consultant. Patients will be referred to Velindre for specialist treatment from within the Cardiff and Vale Health Board and across the South Wales network and SW England such as Bath and Bristol.

As the research-based activity grows it is expected that there will be an increase in cross boundary referrals through consultant-to-consultant referrals.

5.4.2 Days / Hours of operation

The new service will operate

- Day Case Velindre - Monday to Friday 9am-5pm.
- In patient (Velindre and UHW) – Monday to Friday 24/7.

5.5 Workforce

There is requirement to assess the need for adequate infrastructure and workforce models including medical, nurse and research administrative staff to cover work across both sites. Academic Medical and Clinical Oncologist capacity will be necessary to drive and lead, if VCC EPCT and A/T targets are to be realised.

It is also presumed that within this is the CRF CVUHB or CVUHB critical care footprint for Solid tumour for intermediate and high risk. Using a phased approach to introduction of the 'Hub', the following requirements have been considered:

5.5.1 Academic Leadership

Uplift WTE academic medical oncologists/clinical oncologists (staggered and funded by CU and other partners with matched funding by VCC). Such posts will provide leadership and for EPT, ATMP, Early Phase Drug radiotherapy studies (including the Radiotherapy Research Bunker associated with nVCC) and the development of translational research associated with Genomics, Radiation and Immuno-oncology.

5.5.2 Medical Workforce

An uplift in medical capacity is required, this will include

- Clinical Research Fellows supporting these specific research work programmes both in terms of laboratory work as well as patient management within the CRF/Hub TBD WTE.
- "Out of Hours medical cover" which will include middle grade staff such as a SHO that would link with the acute oncology service (AOS) work programme, haemato-oncology and with study Principal Investigators.

5.5.3 Workforce model

Over the next 2 years there will be a need for a flexible and agile VCC research nursing and administrative staff workforce that is able to provide research care over 2 locations, initially working with CRF workforce. This will require rotating staff over 2 sites and working to CVUHB inductions and SOPs. In addition to the current EPT /ATMPs VCC research workforce uplift 2 WTE Band 6.

In the intermediate term the workforce capacity will need to be uplifted to include a Lead Nurse for the overall project, research nurses and administrative staff depending on number and type of trials. There will also need to be an agreed uplift to pharmacy capacity. As the trial portfolio grows medical staff, research nurses and research administrative staff will need to be kept under review.

Pharmacy arrangements such as storage of Investigational Medicinal Product (IMP), reconstitution and drug transportation will be considered by each individual trial. If the IMP can be made at VCC and transported safely, IMP can be stored at VCC, and reconstituted and transported via a courier service. If this cannot be done (due to stability and the timings) VCC would have the drug delivered to CRF for all of the above. This would need to be agreed in the trial set up and appropriate Service Level Agreement organised. For the future and looking forward if the drug is delivered at VCC it should be kept and reconstituted at VCC and vice versa if administered at CRF.

Challenges

The challenge for the service in the longer term is the future requirement to provide 24hr medical clinical cover which will require a change in current service provision, different joint working practices and an opportunity to align the immediate need with the recently established AOS +/- haemato-oncology service.

5.6 Infrastructure

Accommodation for in-patient hospital facilities is described in Health Building Note Standards[2]. Using a phased approach to implementation of the new services the following accommodation will be required:

5.6.1 Immediate - Clinical Facilities

In the first year as a minimum within the CRF VCC will need access to 16 hours (two 8-hour slots) bed/chair hours per week. This is based on previous EPCT activity data that identifies difference in bed hours: the least intensive EPCT requires 3 hours per visit during first cycle of treatment whilst most intensive requires 14 hours per visit bed hours during first cycle of treatment.

- VCC will need access to 1-2 research beds in the critical care footprint for highest risk 1st in human cellular therapies, along with Haematology.
- Access to HCID for Vaccine treatment room and vaccine investigational medicinal product (IMP) preparation room/s (required in the next 2 years at UHW).
- Interventional Radiology- current needs and future opportunities will need to be reviewed to inform planning for intermediate stage.
- Emergency and patient monitoring equipment access to specialised clinical care.

5.6.2 Other

A shared “space” for the clinical and non-clinical workforce to get together is needed. Lab research is spread across many labs and buildings so a “communal” area (such as a shared office / meeting room / coffee room) will be essential for facilitating interactions, new ideas etc. Other requirements include:

- Hot Desk space and IT facilities for attending VCC EPT clinician and nurse/s.
- Overnight accommodation for on call clinician.
- Interactions with unscheduled care.
- Appropriate equipment for PK sampling, and monitoring equipment.
- Use of UHW’s decontamination infrastructure for vaccinations.

[2] Health Building Note 04-01 – ‘Adult acute in-patient accommodation’

5.7 Adjacencies

The future requirements are described below and have been phased for the immediate need and intermediate/long term.

5.7.1 In-patient environment for treatment

When considering the infrastructure requirements for patients having cancer treatments within an in-patient facility, it is important to consider the adjacencies needed to meet infection control, spacing requirements and patient privacy and dignity needs which must, for new environments meet the general requirements of an in-patient ward. This is particularly relevant for some vaccine trials require patients to have en-suite facilities to avoid patient cross contamination as the patient will shed virus.

Figure 10 – In-patient bed area with en-suite

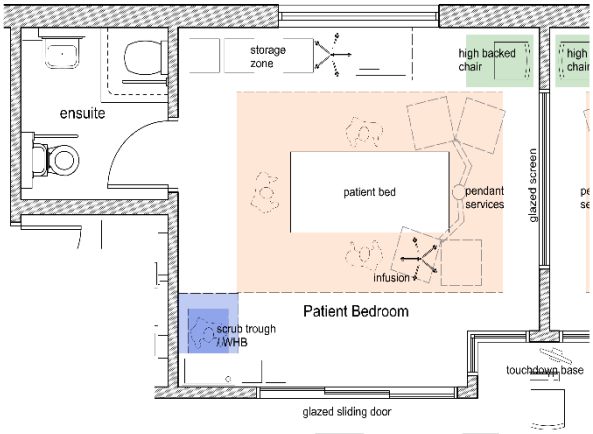
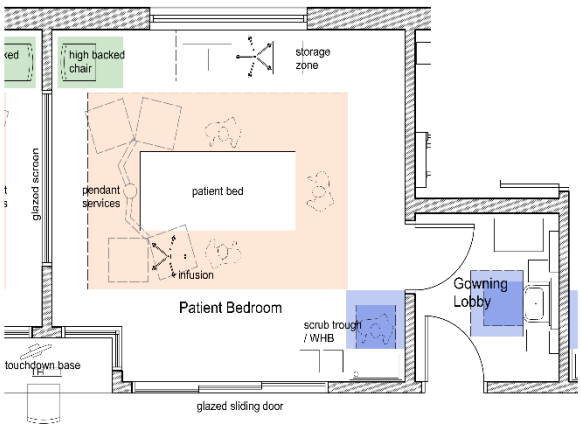


Figure 11 – Inpatient bed area with IPC gowning lobby



For the treatment provided it may be determined that it would be more appropriate to accommodate some patients on reclining chairs rather than in beds. Where this is the case, the room or bay should still be similar in standard to in-patient accommodation with the exception of the bed being replaced by a reclining chair. Facilities should include a shower and provide access to essential medical equipment. A gowning area is also required for staff and the facilities need to separate women from men.

Intermediate Infrastructure Needs – for EPCTs and ATs

This is based on the assumption that EPCTs/ATs are managed within a dedicated location within the Cardiff Cancer Research Hub and have shared facilities with Haem-oncology.

Treatment Areas /Beds/Chairs

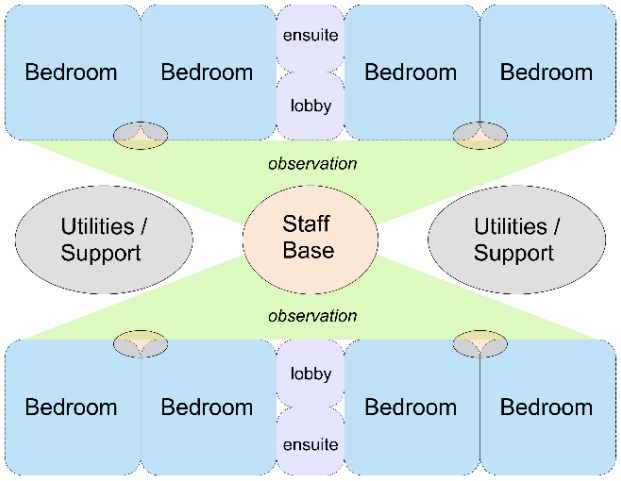
Access to 1-2 research beds in the critical care footprint for highest risk 1st in human cellular EPCTs and ATs. In the main ward areas, there will need to space to accommodate:

- 8 EPT/AT beds, 2 with en-suite facilities and at least 2 beds that can accommodate overnight stay.
- 8 chairs for early & late phase trial patients needing biopsies/investigations/bloods & linking with laboratory research (flexibility around this is required). Spacing between should be taken into account due to immunosuppression and COVID 19.

- Consulting/examination space(s).

Flexible space within newly designed patient areas would be recommended to allow for growth.

Figure 12 - Flexible space arrangement for beds, couches or chairs



Flexible space also allows for areas to be reallocated based on need so that depending on the level of treatment an appropriate facility is provided that is future proofed as therapies change and develop.

Toilets and waiting area space will be needed in the intermediate and long term as well as consulting/examination facility.

A treatment area consisting of a drug cupboard, for emergency support medicines, refrigerator, that is temperature controlled and monitored, and each chair/bed must have medical oxygen and suction outlets.

Emergency Facilities

Emergency equipment and trolley to allow transfer needs to be able to be stored in the facility, or as nearby as possible as well as an emergency arrest and resuscitation trolley, with portable medical oxygen and suction.

Patients need to be able to be monitored and there should be digital monitoring, height and weight equipment, intravenous pumps and stands, vital signs machines blood pressure, pulse oximetry and temperature measuring ability. Two scalp cooling machines. Two electrocardiogram (ECG) machines, with facilities to print out or transmit readouts to study sponsors. Blood glucose monitoring equipment.

Laboratory Area

Within the laboratory that supports the service there should be access to centrifuge machines for blood specimens (including refrigerated centrifuge). Holding refrigerated/frozen blood, urine or other specimens, prior to transfer to the sponsor's research study laboratory facilities.

Storage space for laboratory kits supplied by the sponsor need to be considered. Minus 20°C freezer, temperature controlled and monitored. Minus 80°C freezer, temperature controlled and monitored. A laboratory hood/laminar flow cabinet, sink and separate clinical hand-washing facilities and medical sharps bins.

Vaccines

Whilst this is a requirement for a dedicated area, it is envisaged that the clinic/consultation rooms will become part of this area within the facility in the intermediate and longer term.

Treatment room

Appropriate air extraction to meet the relevant standards in managing the preparation of products that is designed for easy cleaning, with self-coved skirting, coved ceiling/wall and wall/wall. Have junctions and the minimum number of projecting ledges, shelves, cupboards and items of

equipment. Have a sealed ceiling in order to prevent potential contamination from the void above. Have piped oxygen and suction.

Within the room there must be a clinical wash-hand basin. Have a wipe clean standard three-section couch. Consultation area. Include desk space for clinical staff and chairs for the research participant and any attending family members. A curtained examination area. The curtain should be located to prevent contamination from the use of the clinical wash-hand basin.

Vaccine Preparation Room

Certain anti-cancer treatments and Advanced Therapy IMPs (e.g., cancer vaccines and genetically modified materials [GMM]) may need some preparation in a separate area prior to administration. The requirements of this area will depend on the type of product to be prepared, and the need to protect both the operator and the product. Includes a Class II microbiological safety cabinet that meets the relevant standards ducted with appropriate air extraction and has appropriate air extraction to meet the relevant standards in managing the preparation of products in the safety cabinet or on the bench top.

The preparation area should be designed for easy cleaning, with self-coved skirting, coved ceiling/wall and wall/wall. Has junctions and the minimum number of projecting ledges, shelves, cupboards and items of equipment. Have a sealed ceiling in order to prevent potential contamination from the void above. Incorporates an observation panel in the door/wall to the room but not have opening windows. The decontamination of facilities and equipment, or inactivation of waste vaccine/IMP should be by autoclave contamination or chemical disinfectant procedures.

Phlebotomy Facilities

There should be a reclining phlebotomy chair, Clinical hand-washing facilities with glove dispenser. Storage for sterile items, sharps bins work and storage space for clinical research study specific equipment supplied by the study sponsors to the Trust.

Office space

Dedicated work-stations for the people responsible for staffing the unit Doctors, Nurses and Administrative which includes storage for research documentation. Meeting space will also be needed at this stage; a small meeting room for 6 people, room for external trial; monitors, IT requirements for communication needs.

Other patient and relative areas will include reception and waiting area with access to vending machines, toilet facilities for patients and staff and a kitchen facility.

5.7.2 Long Term Infrastructure Needs – Haematology and Solid Tumour

In the longer term there will need to be the uplift to 12 EPT beds, at least four with en-suite facilities and 4 spaces that support overnight stay.

The chairs will also need to increase to 12 for early and late phase trial patients needing biopsies/investigations/bloods and linking with laboratory research.

For Haem oncology patients the number will also need to increase as above. However, the service by this time will be fully integrated and flexibility within the environment will be essential to adapt to treatment changes.

The access to 1-2 research beds in the critical care footprint for highest risk 1st in human EPTs and ATs is considered to remain the same.

Also at this stage:

- There should be consideration of the requirement for a research support office in the hub – facilitating new research development (grant writing, protocol development, ethical submissions etc) and running investigator-led studies which are not suitable (large enough) for CTR support.
- Facilities needed for translational research with university partners, education and training etc, this also needs to support staff development and opportunities for advanced nurse and nurse prescribing positions that not only support the research development but also the junior medical cover as and when required.
- Consideration of other Welsh research infrastructure to be co-located in the hub (e.g. WCRC, ECMC, WCB).

The uplift to staffing should be phased and will be trial dependant but will be supported through additional income along with Haematology generated income through external grants and commercial income in order to offset staff costs. The mix of staffing required to cover the hub overnight will be a key requirement at this stage.

Other infrastructure considerations for the Research Hub

The mixed model of funding will allow for further innovations and developments and will attract staff to get involved in cancer research. For further developments to take place space allocations for the future should include hot desk space for an agreed number of visiting staff (TBD) and a larger room for research meetings and teaching sessions along with some separate office spaces. Digital IT Whiteboards communications with facilities to go across Wales with tripartite communications, signage and new branding.

At this time consideration for a Hub Manager and administrative support will need to be made and usual planning for staff facilities and support should be integral to the design. Office Space including agreed storage for research documentation and external trial monitors

5.7.3 Patients and visitors

Key considerations regarding patient and visitor access, parking, recreational and rehabilitation spaces have been considered and will form part of the design work for the changes to the infrastructure in the short, intermediate and longer term.

5.7.4 Statement of requirements

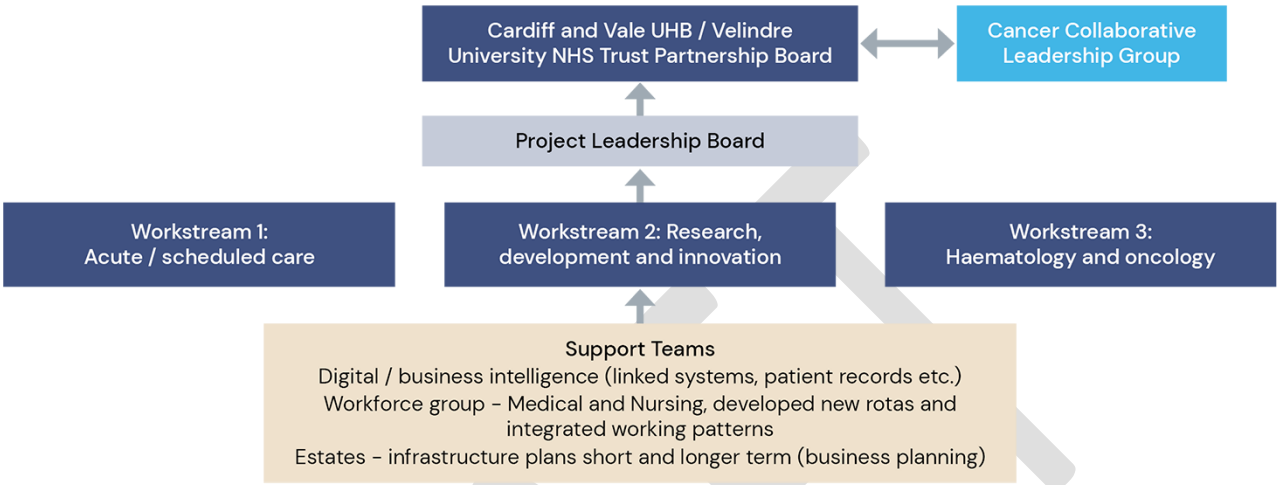
Changes to patients' records, reporting, communication by cross site working

- To be explored and described at the follow up research and development meeting

6 Project management

The management of the project and reporting for implementation of this proposal are demonstrated below.

Figure 13 - Reporting structure for this programme



6.1.1 Project leadership

The project leadership is linked to the different phases for the proposal and described in the overarching project programme.

6.1.2 Governance and key reporting for the proposal

Governance arrangements for the proposal have been considered below along with preliminary agreements on how the project outputs will be monitored and assessed against an appraisal of benefits. These include reporting parameters for:

Quality Performance Indicator	Threshold	Method of measurement	How monitored / reported
Infection Control	National standards for IPC	Trust quality report	Trust quality and safety report
Improving Service Users and Carers Experience	National standards	Patient feedback	Patient engagement/ trust quality report
Reducing Inequalities	National standards	Data reporting	Trust quality report
Reducing Barriers to access	Equality and Diversity	Patient outcomes / Data reporting	Trust quality report
Improving Productivity	Trusts operational performance metrics	Data reporting, income and expenditure	Trust operational performance report
Access to treatment	Trusts operational performance metrics – access to cancer treatments	Trusts divisional operational report/ benchmarking	Trust quality and safety report

Human Resources (HR) considerations will include MOU Contracts and JRO Governance arrangements including:

- Honorary contracts /Letter of access working to CRF and SOPs oversight by the CVUHB Head of Research delivery.
- Associated HR issues with any changes to contracts.
- Financial reimbursements (HCRW Value Based Funding) developed shared costing template.

6.1.3 Key milestones – project plan

A planned approach to implementation of the phased approach and Research and Education milestones (against increased activity expectations) along with assessment of risks for delivery of the project is included in **Appendix 5.**

6.1.4 Summary of existing strategic documents

- Copy of letter sent to SE Wales Chief Executives from Mr Simon Dean.
- Velindre University NHS Trust, Overarching Cancer Research and Development Ambitions (2021-31).

7 Conclusion – next steps

In this report we have assessed the needs of cancer research within the Health Board and the wider opportunity for access to treatments for patients and what is needed to deliver the right level of access to research and trials for patients, that is both inclusive of and accessible to all and meets national standards.

The proposal is fully aligned to the principles of improving cancer outcomes and care and seeks to provide a whole system approach that demonstrates integration of clinical services and academia and has facilitated collaboration and consultation for teams to reach a consensus on the type of care provision required in the future.

The outputs of the proposal meet the aims of a tripartite Cardiff Cancer Research hub to:

- **Increase patient access to research,** including Early Phase and Advanced Therapies for solid cancer and haematological malignancies
- Enable scientists to bring new discoveries through to the clinic by **strengthening the translational pipeline**
- Develop a **focus for cancer research** excellence in Wales to enhance the collective reputation and attract future funding, partners and staff.

Building a baseline understanding of likely future activity and current and future requirements has informed the phased planning. In exploring the range of opportunities for research development has supported agreements for immediate, intermediate and future needs to deliver high quality care for patients safely, the infrastructure needed to be capable of delivering and optimised and accessible service and the likely staffing requirements and opportunities for development.

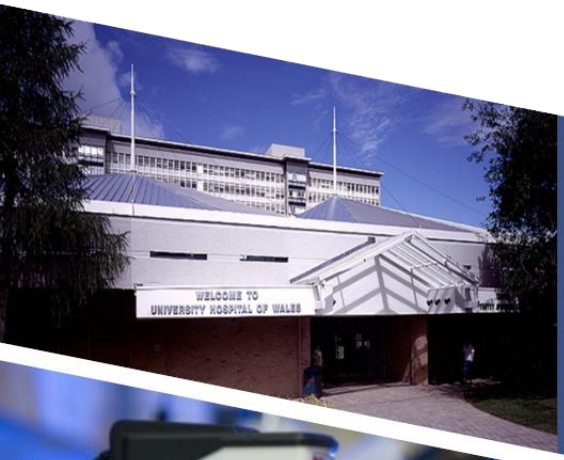
Central to this has been an extensive engagement programme to ensure the priorities being set for both immediate and longer-term research-based activities meet the teams understanding and requirements. Adopting new ways of integrated working has been central to the outcomes agreed within the proposal along with agreeing what premises or services are needed where. This will require careful planning and implementation and investment in resources that determine how the improvements will be demonstrated.

The ‘next steps’ for the proposal will be documented in an agreed project plan and timeline for development, that will be supported and managed by the project implementation team.

Bwrdd Iechyd Prifysgol
Cardiff and Vale
University Health Board

Ymddiriedolaeth
GIG Felindre
Velindre NHS Trust

Appendices



Appendix 1 - Example of improved patient care with Velindre Early Phase Trial success

Without an Early Phase unit at Velindre patients would have had to travel outside Wales to receive their treatment. Having the Early Phase Unit at Velindre Cancer Centre has saved over 16,000 hours of patient travel over the last 4 years (equivalent to almost 2 years of continuous travel).

In the last 3 years, 4 trials have been led by Cardiff based Chief Investigators. This status is recognised by pharma in attracting further research into Velindre.

Results of a Velindre-sponsored multi-centre early phase FAKTION trial, led by Rob Jones as Chief Investigator and opened at 18 sites and VCC, were a huge success. The trail was orally presented at ASCO in Chicago and received significant media coverage including BBC 6 o'clock news. Data was published in the Lancet Oncology, and it became one of Lancet Oncology's highest impact papers of 2020. This put Velindre very much on the international stage and resulted in significant patient benefit. Given the trial involved the most common cancer in the world (oestrogen positive breast cancer) it may lead to a future change in the standard of care for millions of patients around the world.

Although Investigator led, this trial also generated significant commercial opportunities as the IP in the data was protected by the Trust as Sponsor. Pharma has already paid over £1m to licence it and is also funding expensive Next Generation Sequencing of DNA extracted from patient samples by internationally respected Foundation Medicine and Guardant Health to look for biomarkers. This biomarker data, and the yet unpublished overall survival data, may generate further high impact publications if the licenced data is used in an application for a marketing authorisation for the trial drug, which could generate significant further licence fees.

Velindre was also a global leading recruiter to ARADES phase 1 clinical trial which has led to a Lancet Oncology publication. Welsh patients were some of the first in the world to gain benefit from the drug (ODM-201) which has since progressed through Phase 3 with the drug (darolutamide) is now FDA approved in Prostate cancer. Velindre patients were some of the first people in the world to access this drug. Velindre was a leading UK recruiter on Olalparib/abiraterone trial, which was published in Lancet Oncology and formed part of data package leading to the FDA approval of Olaparib in the treatment of Prostate cancer. Additional 23 abstracts presented at high profile international meetings.

Velindre was also a significant contributor to the First-in-Human Phase 1/2 Study of Tisotumab Vedotin study (published in Lancet Oncology) which has progressed to a point where the data will be used in an FDA licensing application later this year

The team have established a portfolio of early phase Drug RT combinations in tumour sites including Head and Neck, Brain and Oesophagus, with further studies extending to rectal, anal and lung cancer opening in 2021.

The future of advanced medical and cellular therapies might be applied to the delivery of combined RT to complement our current portfolio of Drug-RT combinations in partnership with Early Phase/ECMC.

Appendix 2 - Immediate action plan

Ref	Actions	Lead and dates
1	VCC to agree with CVUHB using existing Clinical Research Facility CVUHB for intermediate risk studies, requiring some modifications to existing facilities.	For confirmation following proposal agreement
2	VCC to agree with CVUHB using a refurbished critical care footprint for high risk early phase and advanced therapies (Solid Tumour and Haematological)	
3	Carry forward discussions on the Cancer Research Hub in a hosted Clinical Design Workshop (via Teams), exploring the development of a UHW Research Hub and the 'Velindre@' concept for translational research, advanced therapies research and treatment, and early phase trials	
4	Scope out UK integrated EPT/ATMP workforce models to inform best workforce model approach and associated investment needed	
5	Scope patient numbers and flow, providing scoping report for a shared workforce model Haematological and Solid Cancer EPTs/ATMPs and associated infrastructure, with consideration to the emerging arrangements associated with Acute Oncology Services and translational research requirements	
6	Identify and scope other essential EPT support services and necessary requirements such as the provision of EPT pharmacy services including storage, reconstitution and delivery to CVUHB, Interventional radiology etc.	
7	Develop agreed Tripartite Governance, Leadership and Management structures, setting up a secretariat to set up joint strategic and operational groups for EPT and AT	
8	VCC to formally link with the ATW programme board in particular the ATW RD&I subgroup	
9	Secure academic medical/clinical oncologists, Clinical Research Fellows and out of hours Medical Cover (SHOs) – This Independent SHO level / clinical fellow level cover is needed 24/7.	
10	Prepare business cases to ensure infrastructure requirements to VUNHST Trust Board and Health Board Partners	
11	Review feasibility of the current CVUHB and CU Joint Research Office (JRO) in terms of joint governance for VCC's early phase trials, Advanced Therapies and translational research studies carried out by Velindre in collaboration with CU and/or CAV.	
12	Nursing Model …In the immediate, Velindre will provide some of the current skilled EPT nurses. They will work with CVUHB honorary contracts, complete CRF inductions and follow CRF standard operating procedures and CVUHB policies. Suggest operational oversight could include CVUHB's Head of Research Delivery and VUNHST's Trial Delivery Manager/EPT Team Lead Nurse.	
13	Velindre EPT nurses will work alongside the nursing team in CRF in the shared clinical management of solid tumour EPT patients. This will include following trial legislation requirements and protocol procedures, including communication and information sharing across the two sites, trial drug administration, patient monitoring, associated care and data collection. The VCC EPT team will manage screening recruitment and follow-up of patients.	

Ref	Actions	Lead and dates
14	Seek HR advice on VCC workforce issues in relation to workforce models and job contracts related to out of hours working and working across institutions.	
15	Develop trial SOPs for trial emergency out of hours alongside Acute Oncology Service. Will aim to share many features with haematology-related emergency SOPs. Should make sure they are aligned as much as possible.	
16	Plan shared Operational management of shared training, induction and SOPs research documentation data and shared information systems	
17	Agree research associated financial reimbursement and tracking. VCC Financial Management support required	
18	Engagement with broader set of key stakeholder groups within their institutions seeking collaborative opportunities for shared care, translational research and partner investment. Explore other partner investment such as 3rd Sector, Industry, HCRW etc.	
19	Communicate and promote this Cancer Research Hub EPT/AT initiative with SEW partners and SW England, strengthening patient engagement, information and optimising referral processes to increase research access for EPTs, ATs and translational research.	
20	Scope key partners /stakeholders for Cancer Research Hub and requirements /needs with key stakeholders (partners office space types and size)	
21	Consider joint branding and identity for Cancer Research Hub	

Appendix 3 – Workforce plans

Table 1. Summary of Posts Needed Over 3 Time Periods

- *New posts required during each time period are shown in brackets*

Programmes and staff	Immediate 0-18mths	Intermediate 18mths - 5yrs	Long term 6yrs +
Clinical delivery EPTs/ ATMPs	**WTE**	**WTE**	**WTE**
NHS Consultants	1.2	1.6 (0.4)	1.6
Clinical Academics	2.1 (1)	4.1 (2)	4.1
Clinical Research Fellows	2 (1)	4 (2)	4
Nurses 8a	1 (1)	-	-
Nurse Band 7	-	1 (1)	1
Nurse Band 6	3 (1)	7 (4)	8 (1)
Nurse Band 5	1 (1)	3 (2)	4 (1)
Health Care Support Worker Band 3	1 (1)	2 (1)	3 (1)
Lab Technician/Sample Management Band 4	-	1 (1)	1
Research Admin/Data Manager Band 4	2 (2)	3 (1)	4 (1)
Senior Research Admin/Data Management Band 5	-	1 (1)	1
Pharmacy Technician Band 5	1 (1)	TBC	TBC
Pharmacist Band 8a	0.6 (0.6)	TBC	TBC
Translational Research			
Clinical Academics	-	2 (2)	2
Clinical Research Fellow		1 (1)	1
Hub Education			
Leadership Consultant Grade	-	0.5 (0.5)	0.5
Hub Manager Band 8a	-	1 (1)	1
Project Support Band 6	-	1 (1)	1
Hub Administration Band 4	-	1 (1)	1
R&D			
Facilitator Band 6	1 (1)	1	1
Management accountant Band 5	1 (1)	1	1
Contracts Manager Band 7	-	1 (1)	1
Business Partner	--		1 (1)

Band 8a			
Total	**15.3 (11.6)**	**37.2 (22.9)**	**42.2 (5)**

For Noting:

- The above table combines posts for Haem-Onc (CAV) and Solid Tumour (VCC).

The Hub and associated posts will require a mixed model of funding. Business Cases for Academic posts – to be jointly developed by CU and NHS (VCC or CVUHB.) Other partners will include, Health and Care Research Wales, Wales Cancer Research Centre, ECMC Cardiff, ATTC Midland/Wales/Advanced Therapies Wales, 3rd Sector and Pharma. It is assumed such partnerships (and their associated investment), will deliver levels of ongoing sustainability and growth for this initiative.

Table 2. Capturing Uplift over 3 Time Points

(Fuller Details) Existing posts shown in black, new posts required in blue.

1. Immediate (0-18mths)

Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
Medical Delivering EPT and ATMP Trials				
Current NHS Consultants Haem Onc	0.4	CVUHB Principal Investigators (PIs) will provide OOH advice for Clinical Research Facility (CRF	Y	
Current NHS Consultants Solid Tumour (0.4 WTE) + New (**0.4WTE**) incoming EPT Solid tumour Consultant Oncologist	0.8	VCC/CVUHB PI's will provide OOH advice for) CRF patients	Y	3 years funding secured for 0.4 WTE post (from VCC Charitable funds) - post will need to be continued past year 3
Current Clinical Academic/Consultant Haem Onc	0.8	CVUHB PI's will provide OOH advice for CRF patients	Y	WTE funded by CU (2x 0.4 WTE)
Current Clinical Academic/Consu	0.3	VCC	Y	0.3WTE funded by CU

Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
ltant Solid Tumour		PI's will provide OOH advice for CRF patients		
New Clinical Academic Solid Tumour/Translational	1	CVUHB PI's will provide OOH advice for CRF patients	N/Y	0.5 WTE funded by VCC for 12 months - matched funding opportunities need to be explored with CU for other 0.5 WTE post will need to continue past 12m
Clinical Research Fellow Haem Onc	1	CVUHB Based at CRF On call cover for CRF worked out on a trial-by-trial basis	Y	1 post dedicated to Haematology (jointly WCRC+CVUHB funded) - there are a pool of 2 others non-cancer Fellows who can cross cover in short term
New Clinical Research Fellow Solid Tumour	1	CVUHB/VCC Based mainly at CRF On call cover for CRF worked out on a trial-by-trial basis	N/Y	Velindre funded for 12 months this post will need to continue past 12mths
Nursing / ANP delivering EPTS+ATMPs				
New Senior Research Nurse 8a	1	Some out of hours will be required VCC/CVUHB	N	Velindre funded for **12 months only** to support implementation of collaborative working and harmonisation of processes (**post will not be continued beyond 12m**)
Research Nurse Band 6	2	Some out of hours will be required CVUHB	Y	The CRF (CVUHB) will provide 1WTE Velindre will provide 1WTE
New Research Nurse Band 6	1	Some out of hours will be required VCC/ CVUHB	N	This is **additional** requirement that will be required for out of hours working. Post will need to be continued.

Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
New Research Nurse Band 5	1	Some out of hours will be required VCC/CVUHB	N	This is **additional** requirement will allow release of a Band 6 from VCC for out of hours working. Post will need to be continued.
Allied Health				
Pharmacy Technician Band 5	1	9-5pm generally	N	To support the pharmacy requirements in terms of Trial Feasibility Setting up trials Ongoing Management of trial portfolio Closure of studies Storage Research and Data Management related to trials Management of trial interventional drug This post will be required to continue
Pharmacist Band 8a	1	9-5 pm generally	N	To oversee all aspects of pharmacy requirements Trial Feasibility Setting up trials Ongoing Management of trial portfolio Closure of studies Storage Research and Data Management related to trials Management of trial interventional drug Interactions with Sponsor /Pharma This post will be required to continue
Other				
New Health Care Support Worker Band 3	1	Some out of hours working required	N	Additional to support the clinical staff including patient monitoring

Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
		CVUHB		sample management venepuncture etc. Post will need to be continued.
New Trials/Data Manager Coordinator Band 4	2	9am-5pm CVUHB &VCC	N	Additional 1 WTE to support trial set up, coordination of tests, managing data Second post (1WTE) to come in after 12 months following review & assessment of need. These posts to continue
R&D Business				
New Management Accountant Band 5	1	9am -5pm Joint Research Office (JRO)	N	Manages accounts for R&D (income & expenditure, reporting, negotiate costs with research sponsors and prepare annual R&D budgets. Post will need to be continued.
New Research Governance Facilitator Band 6	1	9am-5pm (JRO)	N	Support to set-up and deliver both commercial and non-commercial research providing complex study oversight. Supports PI's and delivery teams from trial conception to trial completion Post will need to be continued.

Intermediate 18 mths to 5 years

Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
Medical delivering EPTS & ATMPS				
Current NHS Consultants Haem-Onc	0.4	9am -5 pm 5 days a week CVUHB PI's will provide OOH advice as necessary	Y	
New NHS Consultants Haem Onc	0.4	CVUHB PI's will provide OOH advice as necessary	N	Increase pool of NHS consultants with Haem Onc EPT sessional commitment within their job plans

Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
Current NHS Consultants Solid Tumour	0.8	9am -5 pm 5 days a week VCC/CVUHB PI's will provide OOH advice as necessary	Y	Incorporates the additional 0.4 WTE consultant oncologist (originally funded for 3 years) @ yr. 4- add into this
Current Clinical Academic /Consultant Haem-Onc	0.8	9am -5 pm 5 days a week CVUHB PI's will provide OOH advice as necessary	Y	CU funded
New Clinical Academic/Consultant Haem Onc	1	9am -5 pm 5 days a week CVUHB PI's will provide OOH advice as necessary	N	Additional development of EPT portfolio Likely to be x2 0.5 WTE Post will need to be continued.
Current Clinical Academic/Consultant Solid Tumour	0.3	9am -5pm VCC/CVUHB PI's will provide OOH advice as necessary	Y	CU funded Post will need to be continued.
New Clinical Academic Solid Tumour	1	9am -5 pm 5 days a week CVUHB/VCC PI's will provide OOH advice as necessary	N	Additional development of EPT portfolio Likely to be x 2 0.5 WTE Post will need to be continued.
New Clinical Academic - ATMP Clinical Leadership	1	9am -5pm 5 days a week CVUHB PI's will provide OOH advice as necessary	N	Additional leadership needed for ATMP trials working across Haem Onc & Solid tumour Post will need to be continued.
Current Clinical Research Fellows	2	9am -5pm 5 days a week CVUHB/VCC	Y	Existing, presumed continued from 0-18mths

Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
Haem Onc &Solid tumour		On call cover TBC		
New Clinical Research Fellows cross covering Haem-Onc & Solid Tumour	2	9am-5pm 5 days a week CVUHB On call cover TBC	N	Additional posts working in the Hub managing patients and conducting own translational research (MDs etc.) Post will need to be continued.
Out of Hours Cover	Will be provided by Acute Oncology Service (Velindre & CVUHB) on UHW site	Out of hours working CVUHB	N	Depends on AOS/unscheduled care work plan.
Nursing /ANP delivering EPTS & ATMPs				
New Clinical Lead Nurse Band 7	1	Some out of hours working will be required CVUHB	N	Provides nursing leadership &Management for the clinical area. Post will need to be continued.
Current Research Nurses Band 6	4	Some out of hours working will be required CVUHB	Y	**2 WTE posts need to be funded from 5yrs** Cover out of hours shift working covers 8 bed and 8 chairs
New Research Nurses Band 6	3	Some out of hours working will be required CVUHB	N	Cover out of hours shift working covers 8 bed and 8 chairs Post will need to be continued.
Current Research Nurse Band 5	1	Some out of hours working will be required CVUHB/VCC	Y	**Funding to be found after 5yrs** Cover out of hours shift working covers 8 bed and 8 chairs.
New Research Nurses Band 5	2	Some out of hours working will be required CVUHB	N	Additional Band 5 developmental roles Cover out of hours shift working covers 8 bed and 8 chairs. Post will need to be continued.

Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
New Lab Technician /Health Care Support Worker Band 4	1	Some out of hours working will be required CVUHB	N	Additional Oversight of Management of all sample management covering Clinical trials and translational research Post will need to be continued.
Health Care Support Worker Band 3	1	Some out of hours working will be required CVUHB	Y	Funding to be found after 5yrs. Supports the EPT&ATMP Clinical Team and research sample management.
New Health Care Support Worker Band 3	1	Some out of hours working will be required CVUHB	N	Supports the EPT ATMP Clinical Team and research sample management Post will need to be continued.
Allied Health				
Pharmacist Support	TBC	TBC	TBC	
Other				
Trial/Data Management Administrator Band 4	2	9am -5pm CVUHB	Y	Funding to be found after 5 yrs.
New Senior New Trials/Data Manager Band 5	1	9am-5pm CVUHB	N	Additional oversight all of trial coordination and data Management. Ensures collection of performance metrics data metrics.
New Trial /Data Management Administrators Band 4	1	9am-5pm CVUHB	N	Additional support for trial setup coordination of trials and data management.
Translational Research				
New Clinical Academics (developing Translational Research with CU)	2	9am-5pm	N	Driving and developing translational research in partnership with CU.

Level/Tier	WTE	Hours / Locations	Existing Capacity (Y/N)	Additional / Reduced Requirement
Education and Building Critical Mass				
New Consultant Clinical Leadership for Hub	0.5	9am-5pm	N	Oversight and sets strategic direction of Hub and its research.
New Hub Manager Band 8a	1	9am-5pm CVUHB	N	Oversight of the operational running of the Hub including managements of commercial and strategic partnerships to build in Hub sustainability and growth.
New Cardiff Cancer Research Hub Project Support Band 6	1	9am-5pm CVUHB	N	Supports the hub in terms of business cases, grant application performance metrics annual reports and PPI and E. Post will need to be continued.
New Cardiff Cancer Research Administrative Assistant Band 4	1	9am-5pm CVUHB	N	Additional day to day running of Hub meeting rooms, facilities stock ordering management of training/engagement events Supports operational working and administrative functions Post will need to be continued.
R &D Governance/Business				
Current R&D Facilitator – Band 6	2 WTE	9am -5pm Joint Research Office (JRO)	y	Funding to be found after 5yrs.
Current R&D Management Accountant Band 5	1 WTE	9am - 5pm JRO	Y	Funding to be found after 5yrs.
New R&D Contracts Officer Band 7	1 WTE	9am-5pm JRO	N	Contract management supporting the development, implementation and delivery of the JRO sponsor research contracts service. Post will need to be continued.

Later, 6 Years+

All of these posts will be *additional to posts* identified for 18mths to 5 years

Clinical Delivery of ATMP/EPT				
New Research Nurse Band 6	2	Some out of hours working will be required CVUHB	N	Cover out of hours shift working covers 12 beds and 12 chairs.
New Research Nurse Band 5	1	Some out of hours working will be required CVUHB	N	Cover out of hours shift working covers 12 beds and 12 chairs.
New Health Care Support worker Band 3	1	Some out of hours working will be required CVUHB	N	Cover out of hours shift working covers 12 beds and 12 chairs.
New Trials Coordination /Data Manager Band 4	1	9am -5pm CVUHB	N	Additional support for trial setup coordination of trials and data management.
Allied Health				
Pharmacy Support	TBC	TBC	TBC	
R&D Business				
New R&D Finance Business Partner Band 8a		9am -5pm JRO	N	Oversight of financial probity of the R&D Budget, delivering robust financial management process for R&D, including complex financial statutory reports to the JRO and other funders.

For Noting:

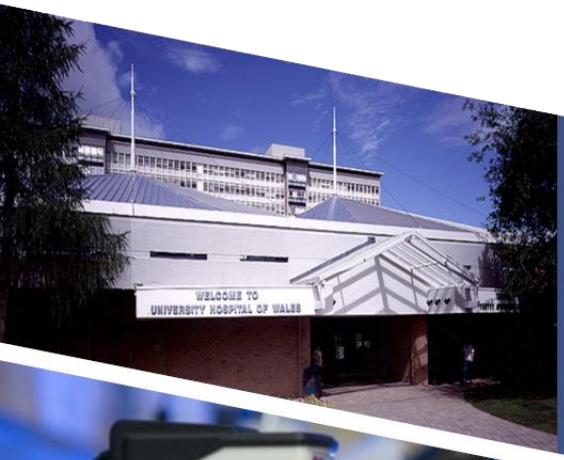
- Medical workforce model meeting held 25/8/21.
- Research Support workforce meetings held 4/8/21, 13/9/21 and 7/10/21.
- Discussions excluded Pharmacy to be assessed by ARCHUS.
- Given early discussions it is highly likely that the Cardiff Cancer Research Hub will be supported and governed within the Joint Research Office based on UHW site, therefore have included R&D Governance posts that will naturally sit within the JRO to demonstrate the uplift in capacity here. Therefore, additional uplift for R&D at Velindre to join JRO for Hub activities calculated by Townsend (HOR, VUNHST.)
- Given the nature of research which is fast changing, including, the emerging trial compounds and associated complex protocols/delivery methods/regimes, recommendations from work force model groups are to keep workforce capacity and capabilities requirements *under regular review*.
- Within cancer clinical research there are a number of departments that provide varying levels of support. Each Clinical research protocol determines the types of department and

areas of support needed it is impossible to assess capacity need, but engagement should occur. Departments include: Pathology, Haematology/ Biochemistry Genetic Labs/Medical Physics/Radiology Nuclear Medicine /Medical Records/ Apheresis Unit /Bone Marrow/ Transplantation Surgery /Cardiology /Audiology /Ophthalmology/ Infection Control /Radiation Protection Respiratory Lung Function/Decontamination Services.

Appendix 4 – Project plan and risk register (next steps for completion by operational leads following approval)

Bwrdd Iechyd Prifysgol
Cardiff and Vale
University Health Board

Ymddiriedolaeth
GIG Felindre
Velindre NHS Trust



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Tripartite Cancer Research Hub @UHW

- developing new infrastructure for research in Wales

Velindre University NHS Trust Board – 27th January 2022

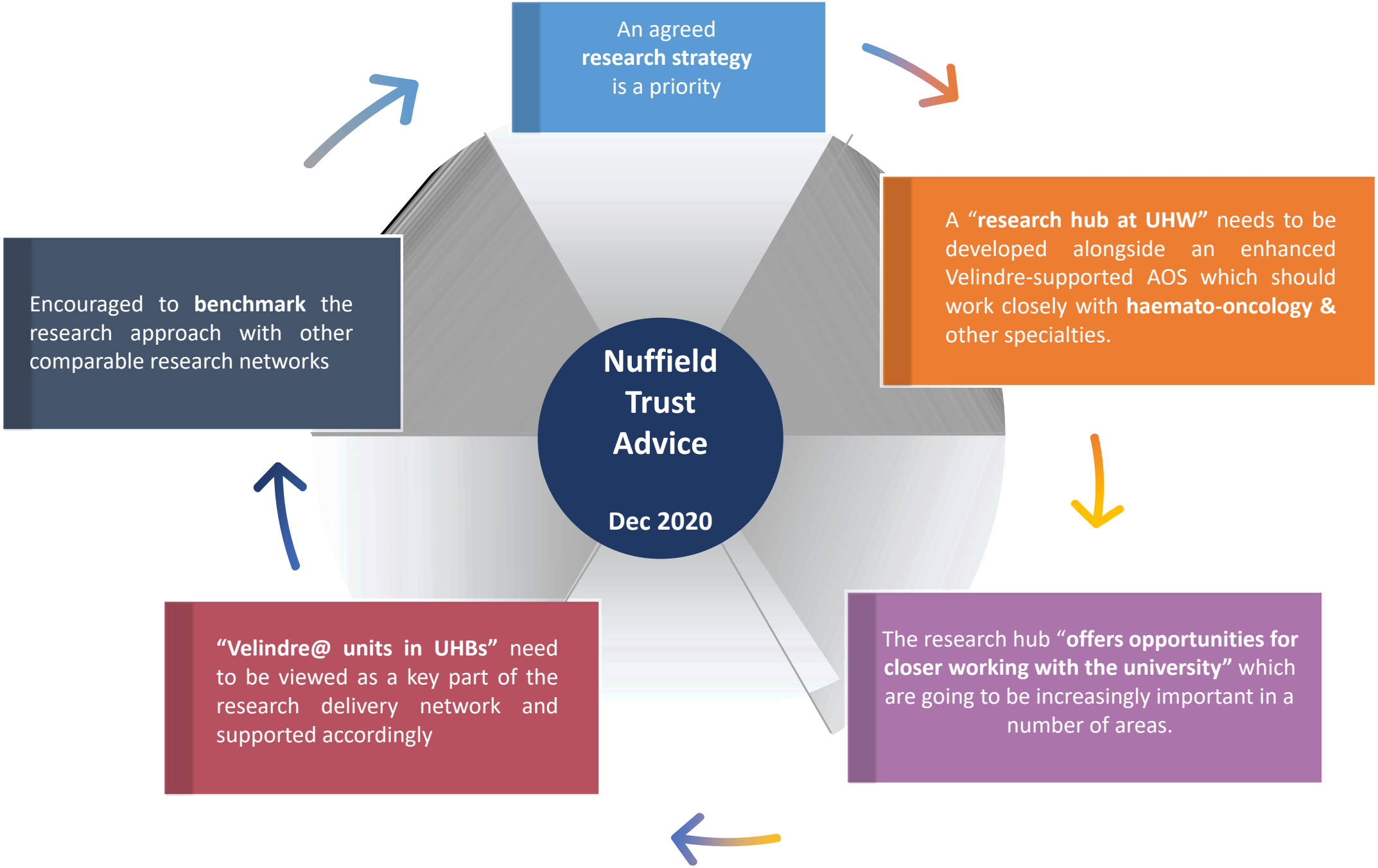
GIG CYMRU NHS WALES
Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Benefits: Today's research tomorrow's Care

- **Increasing patient access to research**, including Early Phase Trials (EPCTs) and Advanced Therapies, for solid cancer and haematological malignancies – for patients across South Wales
- **Strengthening the translational pipeline** → enabling scientists to bring new discoveries through from the laboratory to the clinic & encouraging new scientific discovery
- **Developing a focus for cancer research excellence** in Wales → enhancing our collective reputation and attracting future funding, partners & staff
- **Enabling training, education & innovation** – attracting & retaining staff.


An agreed **research strategy** is a priority
A "**research hub at UHW**" needs to be developed alongside an enhanced Velindre-supported AOS which should work closely with **haemato-oncology &** other specialties.
The research hub "**offers opportunities for closer working with the university**" which are going to be increasingly important in a number of areas.
"Velindre@ units in UHBs" need to be viewed as a key part of the research delivery network and supported accordingly
Encouraged to **benchmark** the research approach with other comparable research networks
Nuffield Trust Advice
Dec 2020

Llywodraeth Cymru
Welsh Government

- Revised admissions criteria for Velindre Cancer Centre to avoid admitting patients at risk of major escalation and to avoid unnecessary emergency transfers of Velindre inpatients.
- Further development of acute oncology services at district general hospitals in the region under the oversight of the South East Wales Cancer Commissioning Leadership Group.
- The development of Velindre hubs, according to local need, at district general hospitals in the region and closer working with haemato-oncology services.
- Specifically, a hub at the University Hospital of Wales for patients receiving complex early phase experimental or advanced therapies; as well as arrangements for ensuring timely access for Velindre inpatients to acute medicine, interventional radiology, surgery and critical care.
- The potential for new regional elective cancer services such as diagnostics and ambulatory care at the new Velindre Cancer Centre.

It is essential that these actions are taken forward and successfully implemented.

I would appreciate a joint response on these matters by 30 June.

Yours sincerely

Simon Dean

I would like to understand progress and next steps with regard to:

- The latest planning assumptions for the development of Velindre hubs at district general hospitals throughout the region; in particular the siting of these hubs and the fit with the Transforming Cancer Services programme intention to rationalise the number of outreach sites to around four to improve the service offer.

- The development of a hub at the University Hospital of Wales for patients receiving complex early phase experimental or advanced therapies; as well as arrangements for ensuring timely access for Velindre inpatients to acute medicine, interventional radiology, surgery and critical care.

I would appreciate a joint response on these matters by 10 December.

1 November 2021

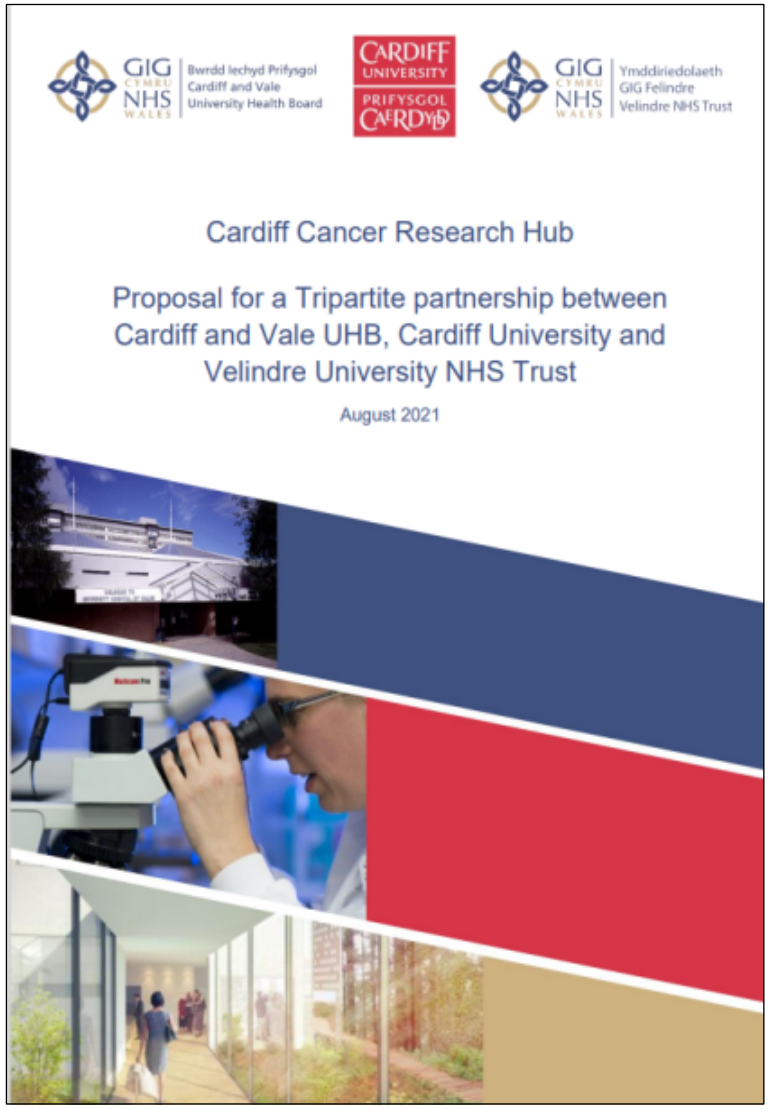
Yours sincerely,

Simon Dean

Llywodraeth Cymru
Welsh Government

Cardiff Cancer Research Hub – A Tripartite Approach

- **Clinical Design Workshop** 8th June 2021 - 3 partners represented, facilitated by Hilary Wilderspin, supported by Archus → basis of draft Proposal/Clinical Output Specification document
- CAV-Vel nursing (x3) & medical **workforce discussions** Aug/Sept 2021 → basis of Appendix detailing hub workforce requirements
- Business cases for Clinical Academic joint appointments – in development (CU & NHS)
- Supported by **CAV-Vel--CU Partnership Board** 3rd August 2021
- Endorsed/supported by **Collaborative Cancer Leadership Group (CCLG)** 22/10/2021– agreed we should continue developing the hub proposal.



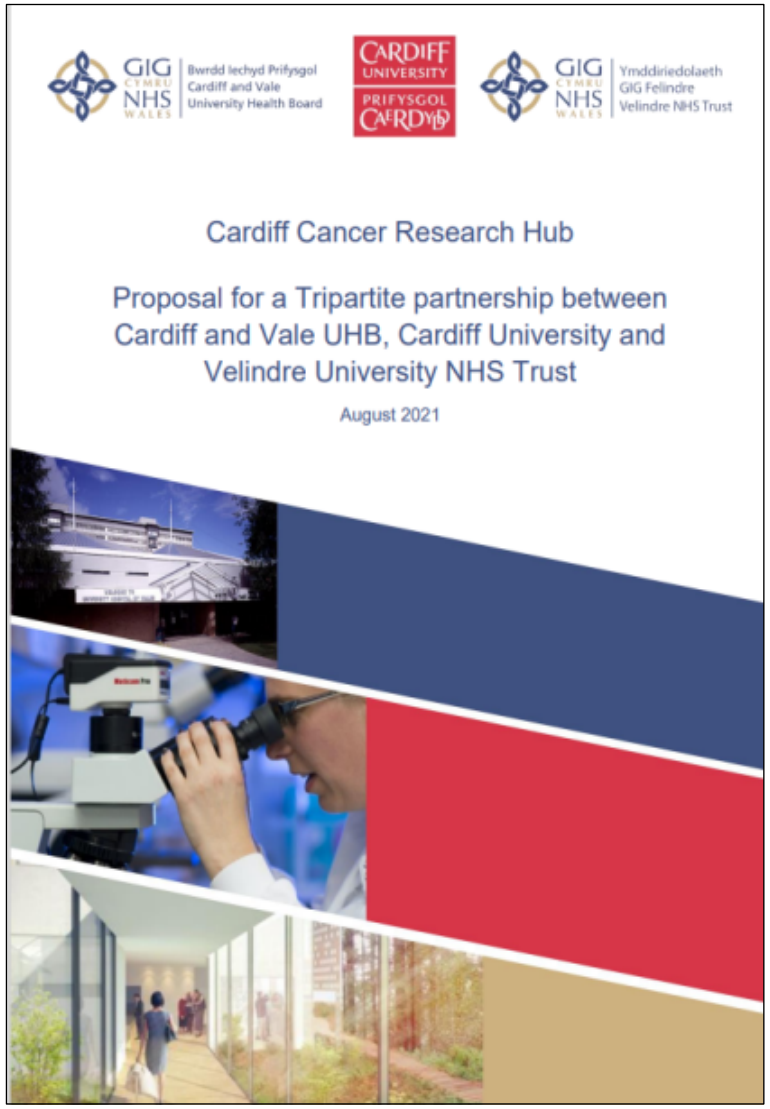
Cardiff Cancer Research Hub – A Tripartite Approach

- 2 principles agreed:

➢ **Dividing studies according to risk** – lowest risk studies at nVCC, intermediate risk & translational on CRF/HCIDU at UHW, highest risk on Critical Care footprint

➢ **Implementation via a phased approach** – starting immediately using existing facilities at UHW whilst working towards establishing the future hub over next 5yrs

- Other principles: close working between solid tumour and haemato-oncology, alignment with AOS (including for out-of-hour cover)



The immediate term

- Using the existing **Clinical Research Facility (CRF)** on UHW site for intermediate risk studies which cannot be delivered at Velindre
- Utilise the **High Consequence Infectious Diseases (HCID)** unit at UHW for studies which require vaccinations
- Use a refurbished **critical care footprint** for highest risk 1st in man studies (solid cancer & haematology)
- For Haem-Onc trials other locations such eg Bone Marrow Transplant Unit may be utilised
- Review of nursing/medical model (clinical research fellows/honorary contracts), investment in workforce & expansion of clinical academic workforce to strengthen “hand off” between pre-clinical & clinical research.

The hub in 5yrs

- **12 beds** for patients in Early Phase and Advanced Therapy studies (combined for solid cancer & haem-onc), 4 with en-suite facilities, 3 for overnight stays
- **12 chairs** for patients taking part in low or intermediate risk research studies who need biopsies/bloods/access to other specialities &/or links with laboratory researchers
- Access to **2 beds** in critical care footprint for highest risk 1st in human EPTs and ATs
- **Vaccine** Prep & treatment room, phlebotomy & laboratory area (centrifuge, flow cabinet, storage & freezers)
- **Shared space** for the clinical & non-clinical workforce to meet, facilitating interactions & generating new ideas
- Located close to AOS (co-located) with easy access to HDU/ITU & other specialities (surgery, radiology etc).

Workforce Models (CU, CVUHB +VCC)

Research Delivery Staff

- Reviewed Oxford Cancer (Haem +Solid tumour) EPT Model
- Considered data on VCC complex trials and timings
- Numbers of beds and chairs including some overnight stays factoring in nurse ratio
- Workforce model group experienced in EPTs
- Pharmacy workforce model
- JRO workforce model discussions - ongoing

Medical Staff

- Patient management requirements
- Out of hours coverage
- Factored the need of building critical mass
- Clinical Academics (Haem-Onc, Solid tumour, ATMP Translational Research Hub leadership)
- Clinical Research Fellows

Cardiff Cancer Research Hub – A Tripartite Approach

Partnership Board

CCLG

CCRH
Senior Management Group

JRO
Governance
Sponsorship
Contracts

Facilitating Research	Driving Research Development	Delivering Clinical Research
○ Education ○ NHS + CU Careers Facilitating: ○ Researcher Support ○ Partnerships ○ Business ○ Performance Data ○ Connectivity	○ Welsh Led Research ○ Translational/Reverse Translational (CU) ○ Research Leadership ○ Building Critical Mass	○ Integrated Model ○ Complex and high risk EPTs, ATMPS Late Phase ○ Translational Research Delivery ○ Interventional Radiology Monitoring

AOS
Out of Hours

PACU

Cardiff Cancer Research Hub – A Tripartite Approach

A Phased Approach 2022-2032

Immediate 0-18mths
Intermediate 18mths - 5yrs
Later 5+ yrs

PHASED NEW STAFFING REQUIRED (excludes pharmacy)

	Joint Research Office For further discussion	Facilitating Research	Research Development	Research Delivery
Immediate	Research Facilitator 1.WTE Management Accountant 1 WTE	-	Clinical Academics 1.0 WTE	Clinical Research Fellow 1WTE Senior Nurse 1WTE Research Nurse 2WTE Health Care Support Worker 1WTE Research Data Manager 2WTE
Intermediate	Contracts Manager 1.WTE	Hub Leadership Consultant Grade 0.5WTE Hub Manager 1 WTE Project Support 1WTE Administration 1WTE	EPT/ATMP NHS Consultant 0.4 WTE Clinical Academic 2 WTE Translational Research with CU Clinical Academics 2 WTE	Clinical Research Fellow 3WTE Team Lead 1WTE Research Nurses 6WTE Health Care Support Worker 1WTE Lab Technician 1WTE Senior Data Manager 1WTE Data Manager 1WTE
Later	Business Partner 1.WTE			Research Nurse 2WTE Data Manager 1WTE Health Care Support Worker 1WTE

A Mixed Funding Model

- **Tripartite Partners: CU, CVUHB & VUNHST**
- Pharma /Commercial Income (EPT currently approx. £379K per annum)
- Wales Cancer Research Centre (2025)
- ECMC, Cardiff (2022-2023 bid)
- Posts secured through Grants
- ATTC Midlands -Wales/Advanced Therapy Wales
- Health and Care Research Wales (Research Delivery)
- 3rd Sector
- Others.

Next steps

- Obtain **governance approvals** in the 3 partner organisations
- Start immediate phase of implementation – enabling the ‘quick wins’
- **Develop business cases** for capital and revenue costs (planning teams)
- Clinical Scientist and **Clinical Academic Business Cases** – to be developed (NHS & Divisional teams in CU)
- Consider alignment with acute care model and integrated workforce plan
- Ensure access to patients & researchers from across SEW to the hub – through the CCLG & partnership boards.